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# Unlimited Horizons

A philosopher has said, "Every man takes the limits of his own field of vision for the limits of the world". The ancients, believing only what they could actually see, considered the world to be flat, with the sun, moon and stars revolving around their particular section of this flatness. When Christopher Columbus was daring and fool hardy enough to sail off the edge of the world, he changed the whole field of vision. Today when we read that the maximum elapsed time by air travel between any two spots on the earth's surface is only sixty hours, our field of vision is enlarged again. Physically there would appear to be unlimited horizons before us. Has our mental or spiritual vision kept pace with this rapid expansion? Can we see the broad professional perspective or is our vision of the future of nursing hampered by our personal shortsightedness?

The recent meetings of the Canadian Nurses Association executive, which will be reported in greater detail in subsequent issues of the *Journal*, provided an opportunity to observe how broad a view the leaders in nursing in Canada have of future possibilities. Provincial representatives, thinking and planning nationally, concurred in the discussions of a wide variety of problems which are confronting us. The report of the Labour Relations Committee which appears on the Notes from National Office page in this issue is a good illustration of the scope of the activities of the national association. As a group we are prepared to support these daring explorers who have a far vision of what is best for nursing and for our patients.

But what about our capacity as individuals to look beyond our own immediate problems? Are we being myopic and so failing to see any horizons at all? Is what may happen to us personally of greater concern than how the profession as a whole shall serve the purposes for which nursing stands? The long

years of war brought unlimited opportunities for nurses, young and old, to serve. By the hundreds and the thousands they joined the armed services. Other thousands who had not thought to nurse again, often at considerable personal sacrifice have returned to fields of duty in order to fill the gaps left by their younger sisters who had gone to distant lands. The impelling demands of war have been met with a loyal agreement that has had an element of grandeur in it. What about the demands of peace?

Reduced to the simplest terms, the functions of our profession are to promote health, to prevent illness and to provide care for those who are sick. Of these functions, the actual day-by-day care of sick persons is the most exacting, the most difficult and, in the long run, the most satisfying. Since this is so, it is difficult to reconcile the repeatedly heard remark, "No more bedside nursing for me!" If we as professional nurses shirk our responsibility, the job for which we are trained, *there are others who will supersede us.* Let us therefore look beyond our immediate field of vision to the unlimited opportunities which await us if we do not allow selfishness, vainglory and shortsightedness to blur the horizon.

—M.E.K.

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## Write to Win

As announced in the May issue, the *Journal* is sponsoring a competition in which nurses all over Canada are invited to participate. The purpose of the competition is to encourage thinking individuals to assess the present situation in nursing and, from that vantage point, to write of their hopes and aspirations for our profession in the years to come. Every nurse who has been following the trend of developments in recent years is aware that there is nothing static in nursing today. Increased industrialization providing more money in the public's pocket-book has resulted in a hospitalization demand which has swamped existing facilities. Shortage of medical personnel has thrown new and more involved responsibilities upon the nurses. More and more nurses' aides have had to be trained to take over the simple routine duties. How are these factors going to influence the future of nursing in your community. Where are we going professionally? What do YOU think about it all?

The competition is open to any Canadian nurse, graduate or student. The articles should be not less than five hundred nor more than a thousand words in length, written or preferably typed (triple-space) on one side of the paper only. The names of the competition judges, who are representative both of sectional interests and of the various areas of the country, will be listed in the September issue. All entries shall be submitted to the offices of *The Canadian Nurse Journal*, 522 *Medical Arts Bldg., Montreal*, 25, and marked "Competition". The closing date for the entries will be *September* 30, 1945. The winning articles will be published in the *Journal.*

Prizes shall be awarded as follows: for the best article, $25; second and third choice, $15 and $10 respectively. Other articles of merit will be given honourable mention. The submitted articles will be adjudged on the basis of the originality of the ideas, the clarity of thought, the pertinence of any suggestions and the ultimate value to nursing of projected plans. It is understood that all articles must be original, have not been submitted elsewhere for publication, and become the property of *The Canadian Nurse.*

—M.E.K.

# Operative Treatment of Deafness—The Fenestration Operation

W. J. McNally, M.D.

Within recent years much has been learned about the ear in health and disease. Better methods of testing hearing in animals enabled physiologists to study the normal function of the ear. Pathological studies in large numbers of human cases added greatly to the understanding of ear diseases. The use of the vacuum tube has enabled physicists to find out more about how we hear and how to improve hearing aids.

A dramatic step forward in treatment has been along surgical lines. Many of the newer drugs have been used in the hope of bringing about improvement in hearing but so far there is no satisfactory form of medical treatment for hearing loss.

The operative treatment is applicable only in certain cases of hearing loss and the proper selection of cases is of the utmost importance.

The suitable case is one in which there is middle ear deafness with the hearing nerve in good condition. The most satisfactory results have been obtained in the young individual in good general health and with normal ear drums and a normal nose and throat. This type of deafness is called otosclerosis. The lesion consists of a bony overgrowth sealing the footplate of the stapes (one of the middle ear bones) in the oval window of the outer wall of the internal ear which houses the cochlea or ear nerve endorgan. The stapes becomes immobile and fails to transmit the sound waves from the drum to the nerve. The operation is designed to make a new opening or window in the wall of the internal ear to replace the one which has been closed by the bony overgrowth. If the ear nerve is not in good condition it cannot conduct the sound to the brain and the operation does not improve the hearing.

The proper selection of cases is not an easy matter because the methods of testing hearing and the equipment for testing hearing, particularly the equipment for testing bone conduction, are not standardized. Testing the patient's ability to hear pure tones by air conduction can be done with a fair degree of accuracy by using an audiometer. The chief difficulties are in testing the patient's hearing for bone conduction and for speech. The bone conduction tests are particularly important in judging the amount of nerve deafness present. It has been determined that the audio-

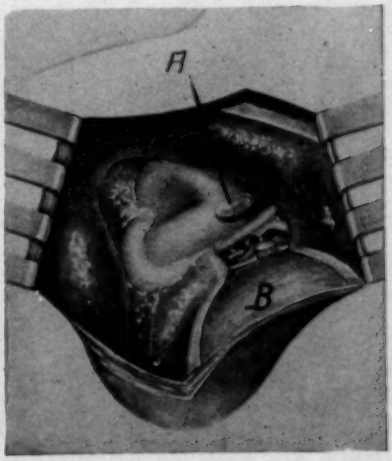


Fig. 1. Drawing showing the fenestra or window A over the ampulla of the right horizontal semicircular canal (stopple in position). B is the skin flap of the external canal attached to the drum. (From Julius Lempert, Arch. Otolaryngol. Vol. 41, Jan. 1945).

meter readings for bone conducted sounds within the speech area — from 512 cycles to 2048 cycles — should be within thirty decibels of normal. The bone conduction should also be tested with tuning forks to confirm the audiometer tests.

The fenestration operation has been in the process of evolution since about 1876. Jack (1895) removed the stapes in sixty patients. Jenkins in 1915 described an operation in which he made an opening in the internal ear through the horizontal semicircular canal. A great difficulty has been to keep the opening in the bony wall from closing. Holmgren (1917) and Sourdille (1929) reported improvements in Jenkins' operation but their operations were in several stages. Lempert (1938) described a technique in which Sourdille's operation was done in one stage and the incision was through the external canal — the endaural approach — instead of behind the ear over the mastoid. Lempert also found that if the opening in the horizontal semicircular canal was made at the ampullated end the window could be made larger and was more likely to remain permanently open. Shambaugh (1942) further simplified the technique by advocating the use of a dissecting miscroscope which provides about seven times magnification and enables the operator to more easily avoid damage to the membranous internal ear when making the new window. He also advocated a continuous flow of irrigating fluid while drilling the window in the bone thus reducing the likelihood of bone dust and blood entering the internal ear.

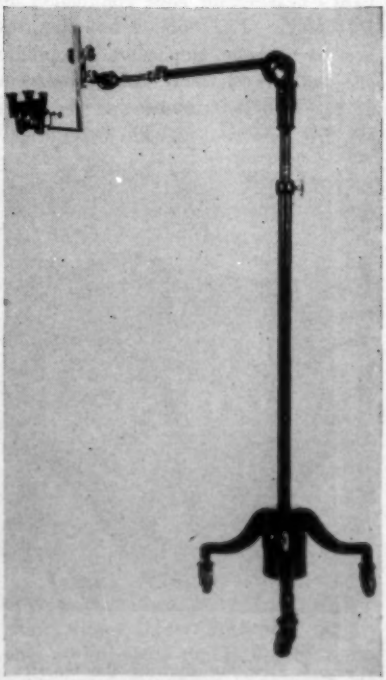

Fig. 2. An operating microscope adapted from a Zeiss Colposcope and an improvised floor mounting. (Mechanical work by Wm. J. Jones, Royal Victoria Hospital, instrument repair dept.)

The operation might be described as a microscopic plastic to shift the ear drum and its attached skin in order to cover the new window leading into the internal ear through the horizontal semicircular canal.

At the beginning of the operation the incision is made in such a way as to enlarge the opening of the external ear canal. Through this opening the mastoid cells are removed and the incus and the malleus, two of the bones in the top of the middle ear, are exposed. The bony wall of the external canal is carefully removed so as to leave the skin of the external canal intact and attached to the drum. The incus is removed and the head of the malleus is excised and removed. The window or opening is then drilled through the ampullated end of the horizontal semicircular canal, care being taken not to injure the underlying membranous canal which is part of the body's balancing mechanism (Fig. 1). This part of the operation is done under microscopic vision (Figs. 2 and 3). A flap of the skin of the external canal is

then cut and the upper part of the ear drum is separated from its attachments so that the skin flap attached to the ear drum is swung inward and placed in position over the new window in the internal ear (Fig. 4).

It is thought that this drum-skin flap in some way carries the sound waves to the new window. It is also thought that the flap tends to prevent the formation of new bone closing the window.

An important consideration at operation is the need to avoid infection, through blood and bone dust entering the internal ear because of the possibility of labyrinthitis and meningitis. If any of these complications occur there may be not only a loss of hearing but even a loss of life.

When the operation was first developed in many cases the bony window closed. This still may occur but it is less likely with the newer techniques. Usually the closure takes place within the first six months but it may occur within the first or even the second year after operation.

The improvement in hearing takes place slowly within the first few months after operation and the hearing may continue to improve within the first post-operative year.

If one considers all the cases that have been operated upon it is probably fair to say that about 50 per cent have had a return of hearing to a practical level. The hearing rarely, if ever, returns to normal. A good result is a gain of twenty-five to thirty-five decibels in hearing within the speech range when the average hearing loss was not more than about sixty-five decibels before operation.

In view of the fact that this operation is still in the experimental stages every patient should be told everything possible about it so that he is in a position to decide as to whether or not he will submit to it. The dangers and complications should be stressed more than the advantages.

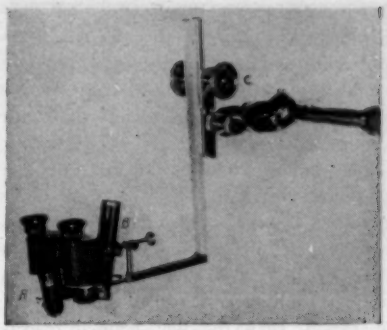


Fig. 3. A close-up view of the microscope showing how we arranged the anterior A and posterior B lights. Also the hand screw adjuster C can be seen. It was adapted from an old microscope. It is placed at ten inches from the eye-pieces to avoid contamination of the hand by the head. The great advantage of the Colposcope is that the focal distance at seven times magnification is 15 cm. This allows sufficient room for manipulating instruments between the wound and the scope.

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It should be pointed out to these patients that they are well suited to wearing a properly selected electrical hear-

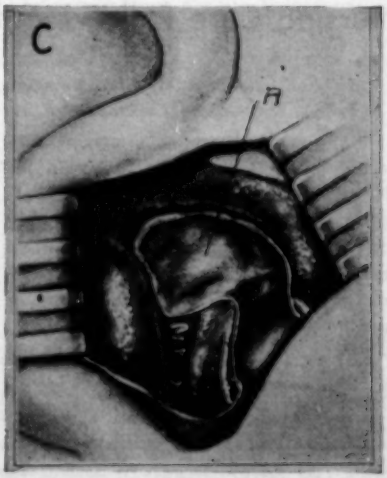


Fig. 4. Drawing showing skin-drum flap A in position over the new window in the internal ear. (From Julius Lempert).

ing aid. With such a hearing aid they could expect to get just as much or more improvement in hearing than they could hope to get from a successful operation. They should also be told that with information gained during the war about vacuum tubes and batteries the post-war hearing aids should be very much superior to any of the instruments now on the market. If the patient has been made aware of all the above facts and he still would prefer to have an operation, then the well-trained operator may feel free to carry out the operation providing he has satisfied himself that the patient is a suitable case. He should not be too much influenced by a patient's willingness to have an operation no matter how poor the chances for success may be.

If progress is to be made in this important problem the patients must be followed for many years post-operatively. The hearing should be tested repeatedly and the results faithfully reported in the medical journals so that operating surgeons may compare their results and all benefit from the contributions of each.


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# Nursing Care Following the Fenestration Operation

BERNICE STEWART

The nursing care of a patient subjected to the fenestration operation for deafness is of particular importance. If infection occurs at operation, it not only lessens the possibility of improvement in hearing, but it is a real threat to the patient's life because of the imminence of meningitis. The operation, in most cases, is a long and difficult procedure and the patient requires careful nursing during the post-operative period. The post-operative care of the wound is almost as important as the actual operation itself. Every effort must be made to avoid the introduction of secondary infection before the wound has completely healed.

The sterilization of the instruments must be done with the same scrupulous detail as would be necessary in the case of a neuro-surgical procedure. All sharp and delicate instruments are soaked in 94 per cent alcohol for twenty-four hours before operation. Drill points, sharp elevators and mastoid curettes are boiled for six minutes in 2 per cent sodium hydroxide. The ordinary instruments, including artery forceps, mastoid rongeurs, etc., are boiled for twenty minutes in soda water. The whole drill head of the electric dental drill is detached and autoclaved, being well oiled with sterile lubricant before and after autoclaving. Two important parts of the technique are the suitable draping of the dissecting microscope (Fig. 5) and of the drill. Before these can be pro-

perly done without danger of contamination a considerable amount of practice by the operating room nurse is required.

In such a delicate operation as this it is most essential that the nurse and surgeon work as a well-trained team. All details must have been previously decided upon by the surgeon and his operating room nurse.

The post-operative dressings should be carried out under strict sterile precautions. Unless there is a special dressing room it is advisable to do the first dressings in the operating room. The detailed set-up necessary should be decided upon by the surgeon and the operating room nurse. As a rule, dressings are done every second or third day and the patient remains in hospital about two weeks after operation. Subsequent dressings are done at the doctor's office, still using sterile precautions.

The post-operative nursing of the patient, as mentioned before, is important because many operators have chosen to use intravenous anesthesia or very heavy pre-operative sedation and as a result the patient may remain asleep for many hours after operation. This requires special vigilance on the part of the nurse to check the patient's breathing, to watch the circulation, to prevent pressure sores, etc. During the first few days post-operative it is frequently necessary to resort to intravenous feeding, when careful note must be kept of the patient's intake and output.

Fig. 5. The microscope fully draped. A special adapter has been devised to keep the drapes from covering the lenses and lights. The eye-pieces are covered by sterilizable rings similar to those used by Shambaugh.

In view of the fact that the new bony window is made into the balancing portion of the internal ear almost all patients are troubled with severe vertigo on awakening. This is frequently associated with nausea and vomiting and may persist for about two to four weeks. The patient must not be allowed out of bed unless supported by some one and must be warned not to attempt any movement of locomotion alone until the unsteadiness has subsided.

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# Laboratory Diagnosis

G. Watson Sodero, M.D.

Laboratory diagnosis is growing in importance in present day medicine. By laboratory diagnosis we mean the chemical and microscopic examination of the fluids of the body in health and disease — the examination of the urine, stools, blood, spinal fluid and stomach contents and in diseased states the examination of sputum and pleural and peritoneal effusions.

Examination of the *urine* is routinely done on every patient entering hospital today. In this way, many cases of unsuspected diabetes are discovered — cases which if given an anesthetic without proper treatment would very likely end disastrously. Cases of latent and unsuspected nephritis are often discovered as are also cases with inflammatory infections of the kidneys and urinary

tract. You may ask why these cases should be unsuspected by the physician. The answer is that the condition may be present without any marked symptoms or with atypical symptoms. Nowadays examination of the urine is done regularly throughout pregnancy. It is not so many decades ago that many women went through their entire pregnancy without having a urinalysis done. This explains why convulsions in pregnancy, not uncommon a few years ago, are comparatively rare today. Some authorities say that practically every case of eclampsia can be discovered early by regular examination of the urine and the development of convulsions prevented by treatment. Estimation of the amount of urea in the urine, following a dose of urea by mouth, constitutes an important test of kidney function.

Examination of the *stools* discloses parasites, pus and blood, and an excess of fat in pancreatic deficiency. The common parasites are pin worms, round worms and tape worms. Pus is present in ulcerative colitis. Gross blood can be detected by a layman but the presence of occult blood in the stools can only be detected in the laboratory. This is of great value when slight, continued bleeding occurs from ulceration or carcinoma of the stomach or intestines. Some cases, by this means, are diagnosed before there are any clinical signs or x-ray findings. In every case of severe secondary anemia, where the cause is not evident, the stools should be examined for occult blood.

Examination of the blood is used in the detection of a variety of conditions. *Blood counts* are most often done to determine whether a patient is anemic and the degree of anemia present. The number of *red cells* (per cu. mm.) is counted and the percentage of hemoglobin estimated. Examination of the patient's eyes or mucous membranes does not tell with any degree of accuracy whether or not a patient is anemic, and it is much wiser to have a blood count done.

The *white cells* of the blood should be counted too. They will be raised in inflammatory conditions, such as pneumonia or appendicitis. They are lowered in tuberculosis and in agranulocytosis—a condition in which the ability of the blood-forming organs to produce this type of blood cell is depressed. Sulfa drug therapy sometimes causes this condition and white cell counts should be done frequently when the patient is undergoing sulfa treatment. The number of white cells is greatly increased in leukemia — a malignant disease of the blood. In the earlier stages there may be no other obvious physical signs.

*Blood smears* should also be made and stained, and a differential count done; by this means the number of each type of white cell is counted and expressed as a percentage. The diagnosis of pernicious anemia is made mainly on the examination of blood smears and often the expert opinion of a pathologist is necessary. By the examination of these smears, the actual size of the cells can be determined by measuring their diameters. In pernicious anemia the cells are larger than normal and this is called a megalocytic anemia. In most secondary anemias the cells are below the average in size and they are called microcytic. Thus a routine blood count may disclose an unsuspected case of pernicious anemia or leukemia.

The *Wassermann test* for syphilis is a complement fixation test using the blood serum. It is now done routinely on all patients in some hospitals, and many more cases of syphilis are discovered which would otherwise go untreated. More and more practitioners are doing routine Wassermann tests on pregnant women, because congenital syphilis in the new-born infant can be prevented if the disease in the mother is discovered before the fifth month and she is given proper anti-syphilitic treatment throughout her pregnancy.

Examination of the blood urea or *non-protein nitrogen* is a test of kidney

function. In more serious cases of renal insufficiency, there may be retention of nitrogenous products, especially urea in the blood, so that the blood urea, instead of being the normal 20-40 mgm. may be considerably raised. This is particularly true in some types of chronic renal disease, sometimes in acute nephritis and in kidney changes, secondary to the obstruction caused by an enlarged prostate. Nowadays, surgeons routinely do this test on their older patients before an operation. They recognize the fact that in days gone by, when the examination was not done, some of their post-operative deaths were due to kidney failure which might have been prevented by proper investigation and treatment. In the pre-operative care of prostate cases this test is used to indicate the most favourable time for operation. It is also used to determine whether the operation should be done in one or two stages.

The *sedimentation rate* is now done fairly frequently. If blood is citrated and thus kept fluid and placed in a vertical tube, the corpuscles settle from the plasma at a fairly constant rate. A great increase in the rapidity of the sedimentation rate is observed in many infections, pregnancy, carcinoma, and other conditions. The test has little diagnostic value but it has its place in prognosis. For instance, the rapid sedimentation rate of pulmonary tuberculosis may become slower as the patient responds to treatment. Similarly the test may have a prognostic value in nephritis and in rheumatic fever — a lowering of the rate indicating improvement. A rapid sedimentation rate is considered as evidence of activity in rheumatoid arthritis, and is taken as one indication for gold therapy.

The *clotting time* is the time taken for blood to clot, normally 1-2 minutes. It is greatly prolonged in hemophilia. The *bleeding time* is the length of time the blood continues to flow when the finger is pricked. Normally it is about four minutes. In certain forms of purpura it may be prolonged. Both these tests are routinely done before the operation of tonsillectomy. If above normal the patient is given calcium and vitamin K, until the tests are normal, before operation is performed. Whether because of this precaution or because the operation is performed more skilfully, cases of hemorrhage following tonsil operations are much less frequent than they used to be.

The *prothrombin time*, estimating the level of the prothrombin in the blood, is a relatively new test. It has to be done daily to control the administration of heparin and dicumarol, two new drugs used to diminish the clotting time of the blood, in such diseases as acute thrombophlebitis.

Examination of the *cerebro-spinal fluid* is so important that no neurological diagnosis can be considered complete without it. Elaborate chemicals and microscopic methods are now available which are of great help in many cases, and frequently essential. Blood is found in the cerebro-spinal fluid in basal fractures of the skull, leakage of cerebral anurysma, ventricular hemorrhage. The fluid may be turbid or definitely purulent in meningitis, especially meningococcal meningitis. A microscopic cell count aids in the diagnosis of tuberculous meningitis and of syphilitic meningitis. Also the fluid may be examined for bacteria and the causative organism identified. A Wassermann test done on the fluid is usually positive in syphilis of the nervous system. When positive in the spinal fluid it is usually positive in the blood, though exceptions occur. The reverse is not necessarily true and neuro-syphilis cannot be established on a positive blood Wassermann alone, even though the signs of a nervous lesion are present.

Examination of the *stomach contents* is an important laboratory procedure and an aid to the diagnosis of pernicious anemia, subacute combined degenera-

tion of the cord, gastric and duodenal ulcer and cancer of the stomach.

It is not necessary that every patient be subjected to all these laboratory tests. The history and clinical examination of the patient, will, in ordinary cases, give the clue as to which laboratory investigations are applicable to that particular case. In any case in which the diagnosis is at all obscure, a complete laboratory investigation should be done. In the past there has been a tendency on the part of the practitioner to limit his investigation because of the fear of putting the patient to unnecessary expense; but in a case where the diagnosis is not evident, the patient's health, and not his pocket book, should be given primary consideration, and no doctor should be called upon to make a diagnosis until he has all the facts at his disposal.

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# Standing Orders for Nurses in Industry

*Editor's Note*: The Committee on Industrial Medicine of the Canadian Medical Association has adopted for use the "Standing Orders for Nurses in Industry", developed by the Council on Industrial Health of the American Medical Association. With the kind permission of this Council, we are reproducing most of the details included in these standing orders which are printed in full in the *Journal* of the American Medical Association, August 28, 1943, Vol. 122, pp. 1247-1249.

## General Relationships

Standing orders represent a preliminary understanding between physician and assisting personnel about routine conduct of a medical service. In establishing such orders in an industrial medical department, several considerations need to be borne in mind:

1. The greater the amount of personal supervision exercised by the physician directly in the industrial environment, the better is the industrial health service.

2. Standing orders cannot be written to meet every situation likely to arise in industry. They must be modified to meet specific requirements and in accordance with the training and professional competence of the assisting personnel. They should be signed by the supervising medical authority and posted prominently in the medical department.

3. The nurse in industry should assume no responsibility for service outside the field of her professional training. This applies particularly to individual case management, from which the nurse should rigidly abstain except: (a) In emergencies demanding immediate independent judgment and action; (b) procedures of preliminary or first aid nature routinely required by reason of the nature of the work and which are clearly stipulated in the standing orders.

This statement confines itself mainly to these last named aspects of medico-nursing relations in industry.

## Emergency Procedure in Industry

General principles which operate in all emergency situations apply to industry as well. They are: (1) Call a physician immediately; (2) stop bleeding; (3) restore breathing; (4) prevent shock and infection; (5) do no more than is actually needed.

The supervising physician should assure himself that these instructions are thoroughly understood and should institute special training when necessary. Nurses in industry should qualify as first aid instructors.

*Emergency Supplies*: Emergency packs with essential sterile supplies should be available at all times in the medical department and in first aid kits suitably

located throughout the plant. Regular inspection is necessary.

*Hemorrhage*: Bleeding calls for immediate attention. The nurse should notify the physician and, until he arrives, proceed as follows: (1) Expose the wound; (2) remove obvious foreign matter; (3) apply pressure.

Direct manual or bandage pressure firmly applied over sterile gauze packing at the bleeding site will effectively control moderate hemorrhage. Indirect compression is indicated in excessive bleeding not controllable by direct methods. Digital compression over the vessel against underlying structures either adjacent to the wound or at the nearest pressure point will usually suffice until the physician arrives. Indirect pressure should be applied proximal or distal to the wound, in keeping with the arterial or venous character of the bleeding. Hemostats or clamps should be applied whenever the emergency warrants it.

Avoid applying a tourniquet if possible. If severe bleeding in an extremity suggests the use of a tourniquet, apply a blood pressure cuff. The nurse should remember that: A direct pressure bandage should not act as a tourniquet; a tourniquet must be periodically released at least every fifteen minutes; no dressing should be applied over a tourniquet; asepsis must be observed at all times.

*Asphyxia*: Cessation of breathing from any cause demands: (1) Artificial respiration *at once* and *at the site of the accident;* (2) notification of the physician; (3) maintenance of body warmth. Avoid excessive heating.

All industrial nurses should demonstrate ability to apply artificial respiration by the prone pressure method and shoud realize the need for its continuous application until breathing is restored or until careful repeated medical examination advises otherwise.

*Shock: Early and adequate shock treatment is life saving. Do not delay.* Common symptoms of shock following injury are pallor, perspiration and rapid thready pulse. Emergency management by the nurse should include: (1) Notification of the physician; (2) removal of cause — if shock is due to hemorrhage, control it. If it is due to trauma not associated with bleeding, all active treatment of injury should be deferred until shock management has been instituted. Wounds should be covered with sterile dressings to prevent infection. (3) Relief of pain: 1/6 to 1/4 grain (0.010 to 0.016 Gm.) of morphine sulfate, repeated if necessary, or barbiturates as routinely ordered except in injuries to the head or trunk. (4) Keeping the patient warm, dry, and on his back with his head low. Avoid overheating.

### Routine Nursing Care of Injuries

Successful medical management of industrial injuries depends on: (1) Prompt treatment; (2) meticulous cleansing and dressing; (3) examination of deep as well as superficial structures.

To accomplish these aims the routine functions of the nurse should be confined to care of minor wounds as follows: (1) Protect wound with sterile gauze while adjacent area is cleansed with soap and water or solvent; (2) discard protective dressing and clean wound margins; (3) irrigate wound with sterile water or isotonic solution of sodium chloride; (4) apply antiseptic of physician's choice; (5) apply dry sterile dressing, interfering as little as possible with function. Sterile dressings should be covered with protective material for use at work. The worker should be instructed not to remove the dressing but to return to the medical department if it becomes loosened or uncomfortable.

*The nurse should do no more than is actually needed.* The following conditions require direct medical supervision: (1) Wounds requiring debridement; (2) those with obvious or suspected involvement of deep structures; (3) wounds with edges which do not

approximate; (4) wounds about the head and face; (5) contaminated wounds requiring tetanus prophylaxis.

*Management of Common Injuries*: Injuries most likely to be encountered in industry include the following conditions:

1. Abrasions: Clean and apply dry dressing. Extensive or deep loss of skin, especially about the fingers and hands, needs medical attention.

2. Contusions: Treat with cold compresses directly following injury, later with moist heat. If soreness or disability persists or if deep involvment is suspected, refer to the physician.

3. Lacerations: Clean and apply dressing as directed. Any possibility of injury to joints, nerves or tendons should be brought to the physician's attention at once.

4. Puncture Wounds: Puncture wounds through the skin need direct medical supervision to avoid or treat severe infection. If superficial, clean and apply sterile dressing.

5. Slivers and Splinters: Penetration through the skin by slivers or splinters always carries the risk of an infected puncture wound and should be treated as such. Those lodged superficially and easily removed without added trauma or incision may be extracted aseptically by the nurse.

6. Burns and Scalds: Clean minor burns with soap and water. Apply petrolatum or 5 per cent boric acid ointment, bandaging firmly without interfering with function. Leave blisters alone.

In all other cases: (a) Notify the physician; (b) cover the burned area with a sterile dressing or sheet moistened with isotonic solution of sodium chloride or 5 per cent sodium bicarbonate solution; (c) combat pain and shock.

In the absence of specific orders, chemical burns should be treated by irrigation or immersion in water for at least twenty minutes and then by dressing.

7. Sprains and Strains: Treat first with cold compresses, elevation of the part and rest. A physician's advice is necessary regarding strapping, other methods of support or fixation, further examination or special therapy.

## Eye Injuries

Rigid aseptic technique must be scrupulously observed in all eye conditions. Never attend consecutive patients without sterilization of instruments and careful hand washing. Remember that early symptoms of infection simulate foreign body.

*Minor Burns*: Do not apply ointments to minor burns of the skin about the eye. Apply a sterile dressing and refer to the physician.

*Burns of the Eye*: 1. Chemical Burns: Irrigate chemical burns of the eye *copiously* and *at once* with water, preferably by immersion. Neutralizing solutions are usually inadequate or unavailable. The rapidity with which the irrigation occurs is more important than the type of solution used. Continue to irrigate at least twenty minutes by the clock.

2. Hot Metal Burns: Apply a sterile pad and refer at once to a physician. Do not irrigate. An anesthetic should be applied as ordered by the doctor. *Every burn of the eye should receive competent medical attention early.*

*Foreign Bodies*: The nurse should attempt to remove only those foreign bodies of the eye which can be readily located and which can be easily washed out or removed with a dry sterile cotton applicator. An antiseptic may be applied if the physician so orders.

Direct medical care is essential: (1) If the foreign body cannot readily be located — stains to aid in the location of foreign bodies should be used only on specific medical order; (2) if removal requires any instrumentation; (3) if irritation or pain persists after removal.

*No person with an eye injury should be discharged without examination by a physician.*

*"Flash" Injury*: First aid treatment should include local anestheic as ordered; cold compresses; sedatives. Persistent pain following flash needs medical examination and treatment.

*Conjunctivitis*: Conjunctivitis or other forms of conjunctival irritation should be referred routinely to the physician or ophthalmologist.

### Fractures

Preliminary steps for the nurse are: (1) Call a physician at once; (2) keep the patient quiet and warm; (3) immobilize before any movement is attempted; (4) do not attempt reduction; (5) if the fracture is compounded, cover the site of the fracture with a dry sterile dressing. *Do not cleanse or reduce.* Special instruction in splinting should be provided every industrial nurse.

### Head Injuries

Until the physician takes over, the nurse should keep the patient lying down; elevate the head; apply ice cap or cold compress (no sedatives); record pulse and respiration every ten minutes; clip or shave and cleanse areas adjacent to scalp lacerations, and cover with a sterile pad.

### Chest and Abdominal Injuries

Contusions of the chest and abdomen with or without external evidence of injury may result in trauma to underlying organs. Until seen by the physician, such patients must be kept warm and quiet; allowed no sedatives; have pulse, temperature and respiration recorded frequently; suitably bandaged to avoid contamination; in case of abdominal injury give nothing by mouth.

### Non-occupational Illness

Treatment of injury or illness which has no relation to occupation is not a function of the industrial medical department except:

1. First aid for emergency sickness. Such measures as the situation demands must be taken until notification of the family physician discharges responsibility.

2. For minor ailments which temporarily interfere with an employee's comfort or ability to complete a shift and for the relief of which a physician would not ordinarily be consulted.

In all relationships of this kind, judgment and tact are required of the industrial nurse. Several principles apply: (1) Before giving any treatment, the temperature, pulse, general appearance and a history of the presenting complaint should be recorded; (2) palliative treatment, especially for chronic or recurring disorders, should not be repeated.

Every properly trained nurse understands the difference between attention of this kind and systematic treatment.

### Care of Minor Illness and Symptoms

Persistent or augmenting symptoms of irritation, discomfort or disability suggest faulty work environment. The nurse should not hesitate to ask for medical examination of workers and of the premises.

*Fever*: A rise in temperature of 1 degree suggests medical consultation before work is resumed. Findings should be checked by repeated thermometer recordings.

*Headache*: Record temperature. If headache is accompanied by dizziness, nausea, vomiting, stiff neck, injury, history of recurrence, fever, general mal-

aise or other symptoms the patient needs medical attention. If not, give an analgesic as ordered by the physician. Remember that headache or dizziness may be premonitory signs of intoxication.

*Unconsciousness*: 1. Fainting: Usual symptoms are pallor, with shallow breathing, slow and weak pulse. Period of unconsciousness is of short duration. Keep the patient lying down with head lowered until fully recovered. Be sure the patient has plenty of fresh air. Clothing should be loosened and stimulating inhalants used, such as ammonia or smelling salts.

2. Other causes: If other signs are present or if unconsciousness persists longer than a few minutes, call for medical assistance. *Give nothing by mouth.*

*Toothache*: If there is a cavity, the nurse may pack it with cotton dipped in oil of cloves for temporary relief. For further examination and treatment refer to a dentist.

*Nosebleed*: Spontaneous nosebleed may be treated by cold packs or pinching the sides of the nose against the septum. Keep the patient sitting erect or standing and loosen the collar if it tends to constrict the neck. Advise the patient not to breathe or blow through the nose for an hour or two after bleeding has stopped. Bear in mind that certain occupational exposures are manifested by nasal damage and bleeding.

*Sore Throat*: Patients with sore throat may be given a hot saline gargle if they have a normal temperature. Do not "paint" the throat. Any persistent sore throat or one associated with fever needs medical care at home.

*Respiratory Irritation or Infection*: Repeated or persistent signs of bronchial or chest irritation without associated infection suggests an unfavourable occupational exposure. A plant hygiene survey is indicated. Persons having acute respiratory infections with elevated temperature, cough, sneezing or nasal discharge should be sent home for proper segregation, rest and medical attention. In mild infections, work may be continued, if under medical or nursing supervision simple measures will control symptoms and prevent spread.

Available medical evidence at the present time cannot support routine administration of cold vaccines or vitamin preparations as methods of reducing the incidence or severity of acute respiratory infections. Frequent colds or chronic respiratory conditions require special medical consideration.

*Abdominal Distress*: Early signs of occupational intoxication may be abdominal in character. In any case abdominal distress, nausea or pain, especially if severe or persistent, requires competent medical diagnosis and management.

*Laxatives should never be dispensed from an industrial medical department.*

*Dysmenorrhea*: Painful menstruation not associated with fever or gastro-intestinal disturbances may be treated with an analgesic ordered by the physician and the patient placed at rest with heat to the lower part of the abdomen. If there is no relief or if other signs or symptoms present themselves, she should be referred to her physician.

Patients with recurrent severe dysmenorrhea should not be given palliative treatment. They should be referred for examination and treatment.

## Dermatitis

Management of skin disorders in industry depends on cause.

*Specific Irritants*: Materials or processes in the plant capable of causing skin disease should be identified and special orders provided for control. Competent dermatologic consultation is essential in all obscure or refractory situations.

*Non-specific Skin Disease*: Non-specific skin irritation in industry is almost entirely assignable to faulty personal hygiene. The nurse can do much to improve washing routine, the use of de-

pendable protective coverings, the wearing of clean work clothing, maintenance of satisfactory housekeeping in the plant and the general maintenance of accepted hygienic procedure.

### Pregnancy

A definite policy regarding employment during pregnancy should embrace the following recommendations:

1. The employee should notify the proper authority in industry about her pregnancy within the first trimester.

2. She should obtain a statement from her own physician (a) that her work is not contra-indicated; (b) regarding the length of time she should work.

3. Special attention should be given to the nature of the work. Pulling, pushing and lifting must be kept within safe limits. Rest periods will tend to minimize emotional and physical instability during pregnancy.

4. Ordinarily work should terminate by the thirty-second week (within six weeks of term). If contra-indications arise within this period, the employment should stop.

5. Return to work is inadvisable before six weeks after delivery and then only on notification of the employer by the physician.

### Equipment and Supplies

Space which can command privacy and which can be kept clean and properly prepared for emergency and routine services by the nurse should be provided in the plant. Special attention should be given to heating, light, ventilation and accessibility.

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# Nursing Care for All the People

Gertrude M. Hall

The whole field of professional and vocational nursing is one of such complexity that one cannot begin to present all aspects in one easy lesson. I shall take it for granted that all are familiar with the many excellent articles relating to this subject which have appeared in our nursing and hospital journals. Some of the very best have been prepared by eminent members of the medical profession. I refer particularly to "The Future of Nursing", which was given by Dr. H. B. Atlee at the biennial convention in 1938 and was later published in *The Canadian Nurse* in September, 1938. Dr. Joseph Mountain, medical director, United States Public Health Service, published an article in the April, 1944, *American Journal of Nursing*, "Suggestions to Nurses on Postwar Adjustments". Everyone, we trust, has studied "The Preparation for Professional Nursing" by Nettie Fidler, in which Miss Fidler has presented very clearly the problem in relation to the Canadian situation. These are but a few of the interesting and informative sources of material for study.

Do we as a group really know what we mean when we talk about subsidiary workers? At one of the provincial annual meetings which I had the privilege of attending recently, a panel of nurses and a lay woman discussed the subsidiary nursing group. Following the presentation by the speakers, the discussion from the floor revealed much confused thinking. Many nurses were

totally uninformed on these important issues. If we as a professional group do not know what is happening within our profession and what is likely to happen, unless we are prepared to give leadership and direction, how can we be critical of the lack of an informed public? Can we censure lay people when they employ women to care for the sick who lack what we consider to be the essential qualifications and preparation? What is our responsibility? How can we as individuals inform the public intelligently. These are questions that every nurse must ask herself at this time. I quote from an article which appeared in *Hospitals*, October, 1944, "Some Trends of Today that will help Shape Tomorrow's Hospital", by F. G. Carter, M.D., superintendent, St. Luke's Hospital, Cleveland:

> War necessities have demonstrated previous statements that 50 per cent of nursing duties were of a non-professional nature, to be very conservative. We have seen women, trained in as little as eighty hours, do in creditable fashion numerous tasks which previously many nurses had claimed should be done only by professional nurses.
>
> Hospitals cannot afford to pay professional salaries for non-professional work. Some kind of adequate bedside nursing is the backbone of good hospital service, yet our nurses are being educated to the point where they have an investment that does not permit them to do the simpler types of nursing. When hospitals pay professional salaries for such tasks they are paying for talents that are not needed and are not used.
>
> Some one, preferably the nurses themselves, must sift out of nursing all the activities which can be carried on by people of non-professional status. What we need in the hospital and health fields today is a less highly trained group for routine duties and a more highly trained group for medical technical service of all kinds. A vast field awaits cultivation in the latter area and the nurses are the logical ones to do the cultivating.

Here is a challenge to nurses to so inform themselves that they may participate in formulating plans for the preparation of more than one type of nurse.

In the May, 1945, *American Journal of Nursing*, there appeared an article by Edward L. Bernays, public relations specialist, entitled "The Nursing Profession — a Public Relations Viewpoint". He states:

> Good public relations between the nursing profession and the public depends on two factors. One is that you and the public understand each other; and the other is that you definitely meet the real needs of the public for nursing service.

One of our objectives, as stated in the Constitution and By-laws of the Canadian Nurses Association, is: "To elevate the standard of nursing education and practice, in order to render the best type of public service". Similarly, each of the Provincial Registered Nurses Association Acts has as one of its major objectives a statement such as: "To maintain the honour and status of the nursing profession and render service in the interest of the public".

This immediately raises questions which we must seriously consider. Are we sincere in these statements? Are we really concerned with the necessity for the provision of a complete nursing service, both preventive and curative, for the nation, taking into account questions of demand and supply and putting available skill to the most profitable use in the interests of the public? If we can answer those questions honestly and frankly, then we are ready to take the next step in our approach to a study of the ways and means by which adequate nursing service can be provided for all the people.

More than two years ago, in January, 1943, to be exact, our own *Canadian Nurse Journal* published Section 1 of the report of the Nursing Reconstruction Committee for Great Britain. It will be recalled that this report was prepared by a committee sponsored

by the Royal College of Nursing, of which Lord Horder, M.D. is the chairman and Miss F. Goodall and Mrs. H. M. Blair-Fish are joint secretaries. The report differs from all previous surveys of nursing service and nursing education, because it assumes that the position of the assistant nurse is pivotal and that "her status offers the key to the improved training and employment of her senior partner, the State Registered Nurse".

The first section of the report concerns the instructions, qualifications, control and employment of the assistant nurse. It may be asked why the section of the report dealing with this grade of nurse should take precedence over those sections which concern the State Registered Nurse, but a review of the position from a national rather than a sectional angle shows that the position of the assistant nurse is pivotal. Far from lacking importance, the assistant nurse of the future, as envisaged by the committee, should become one of the most stable elements in the national nursing service, an integral part of the profession and, again we repeat, a person whose status offers the key to the improved training and employment of her senior partner, the State Registered Nurse. Moreover, it is only when the services of the assistant nurse have been defined and regulated that matters affecting the State Registered Nurse can be brought into line. When carefully studied and analyzed, the British approach to the complex problem of solving total community needs seems most logical.

Turning now to the Canadian scene, there is not at the present time, nor has there ever existed in Canada, a Nurse Practice Act. Any woman, with or without training, may wear a nurse's uniform and present herself as one skilled to give nursing care. If, however, she calls herself a registered nurse and is not entitled to do so, she does so in violation of the various Acts respecting registration. Other than this, she may call herself a "nurse", render care to the sick and accept remuneration for so doing. There are no data at hand which would reveal the extent to which women without training, or with little training, render nursing service for remuneration. It is definitely known that there is an undetermined number of women without any training whatever who accept calls for nursing care and are remunerated for their services. Legislation to provide for licensing and enrolment would bring this group into the open. Then some preparation for service could be given and supervision of their activities would be possible.

It is not an exaggeration to say that the people of Canada never have been provided with adequate nursing service. Within the whole structure of nursing service there are inherent defects which operate less conspicuously in normal times, but in periods of stress, such as economic depression or world war, the results of these defects are cumulative and are frequently misinterpreted as causes. It would be impossible to overstate the complexities of the whole problem of nursing in Canada and elsewhere. In Great Britain and in the United States, research committees have been working toward amelioration of nursing problems, and it will be necessary for us to keep in touch with findings and recommendations of these committees, since nursing is international in its philosophy and organization and many reciprocal international agreements have been in effect for a number of years. These agreements do not, as yet, include any but nurses who are registered according to their own provincial and national legislative acts, but the time may not be far distant when this reciprocity may be extended to include the licensed practical nurse.

It is conceded by those who are competent to judge in Great Britain, Canada and the United States, that there is a place for the services of the "assistant" or "practical" nurse, but that ser-

vice must be directed, supervised and controlled by legislation. While I do not propose to deal with all the problems of professional nursing, it must be acknowledged that those problems and the problems of the subsidiary worker as so interrelated as to be inseparable, and these combined problems have a grave and direct bearing up adequacy or inadequacy of nursing service. There are certain factors which should be kept in clear focus by any agency vested with responsibility for the administration of legislation respecting the subsidiary worker in the nursing field. Very briefly, then, some of these factors are:

1. Nursing care has up to the present depended upon the patient's financial status and not upon his actual needs.

2. There is not at present, nor has there ever existed, any satisfactory plan whereby nursing care might be graduated according to the degree or type of illness. Frequently when a patient could afford his own "special nurse" there has been a tendency to retain her services long after he required the services of a professional nurse.

3. There has been faulty distribution of skilled nursing care because nurses, like other professional workers, have shown a disposition to remain in or gravitate toward the larger centres where living and working conditions have been more satisfactory.

These are factors which must be kept in clear focus before proceeding to legislate for the non-professional or subsidiary group. They, too, require the sense of security that stems from the assurance that they are, or will be, adequately prepared for the work they will be called upon to do, and from the knowledge that they will enjoy a certain amount of economic security and feeling of personal worth. Such legislation must protect them from exploitation of any sort.

Our concept of the words "nursing care" is undergoing a rapid change. This is due in part to trends and developments occurring during the war. Many duties once considered the sacred prerogative of the graduate nurse are now being done, and well done, by partially trained people. The lay worker who can give baths, make beds, take temperatures and do much of the routine care of the patient will have to be trained and carefully prepared for his or her tasks in the care of the sick, but on no such elaborate scale as that of the professional nurse.

A "break-down" of services rendered to the patient during illness reveals many duties which might be performed by the "practical nurse" without danger to the patient. As an example — let us analyze the nursing care given during a typical day to a few representative patients in a general hospital, such as:

Mrs. L. — diagnosis, diabetic: T.P.R.; pre-breakfast care; breakfast; bath and change of linen; medications (and protamine zinc insulin); luncheon; trip to x-ray for special studies; rest period; visit and examination by staff doctor; afternoon nourishment; T.P.R.; afternoon care; medications; supper; last attention for the day.

Of the above list there are just two items which must actually be in the hands of a graduate nurse or of a student nurse under supervision, and they are the two items during the day (totalling perhaps fifteen minutes) when medication is given to this patient. All the rest of the care given her might just as well and quite as safely be given by a trained worker. The exception is, of course, expert observation.

Another example is: Mrs. V. — fifth day post-partum; nursing care much as outlined above, with the following exceptions: with morning bath, breast care; with bed pans, perineal care; babe to breast every four hours. The care of this patient, with the exception of the noted items, may be done by a trained worker. In fact perineal care is now being introduced as part of the regular technique to be taught volunteer Red Cross Nurses Aides in the United States. The daily

inspection of breasts, fundus of the uterus and lochia is part of the duty of the head nurse, while the routine care may be delegated to others.

On the other hand, let us consider the care required by Mr. C. B. — first day post-operative prostatectomy. Proper care of this patient includes watching drainage for bleeding and pulse for shock; irrigation of tubes; careful check on intake and output with forcing of special fluids; assistance given to doctor in redressings, administration of nursing measures and narcotics for pain; encouragement given patient during period of depression following operation. Most of these duties could not be delegated to an untrained worker. This is a *sick* patient who requires skilled nursing care, and whose symptoms may indicate changes in his condition, which anyone less well trained than a nurse could not be expected to see.

But what happens? In many cases all three of these patients are provided (at great difficulty by the hospital) with equal amounts of care by the professional nurse with the result that the really ill patient is neglected, while the less ill patients are waited on by persons whose time should go to the care of the really sick.

In hospitals with sufficient registered nurse staff, adequate supervision of the trained worker is feasible. In the home it may not be quite so simple. If the patient receiving home care required only part-time services of a professional nurse, this could be arranged on an hourly basis with the trained worker remaining in the home to take care of the more simple duties.

This raises the question as to why practical nurses are so frequently requested for home care. When the patient is the homemaker, there are homemaking duties to be performed. Both the professional and non-professional groups have frequently reported that these home-making duties are required of them. It is interesting to recall that in the Weir Survey Report (1932) it was revealed that 85 per cent of registered nurses giving nursing care in homes expressed a willingness to perform these light home-making duties. There have been, however, many instances of the home-making demands exceeding the point of reason and interfering with the nursing care needed by the patient. If the home-making tasks are heavy and the services of a housekeeper are required, it might be possible to meet this need through a visiting housekeeper service, with nursing care arranged on an hourly basis. The hours of service provided at the present time by the group are in excess of what could reasonably be expected of any human being. There is room for reform in the practice of employing women for twelve, fourteen, sixteen and twenty hours daily, and an exposure should be made of the extent to which the public exploits this group. Long hours of service in the home in an occupation which is exacting and arduous are not compatible with the efficiency and health of the worker. There could be no justification for the practice of undermining the health of one group in an effort to restore the health of those already suffering from illness.

There would seem, too, to be sufficient evidence to indicate that the practical nurse is called frequently when the services of a fully trained nurse are required by the patient and when the family engaging her could well afford the best service available.

To an undetermined extent, physicians are asking this practical nurse group to perform certain procedures which can only safely be undertaken by the fully qualified nurse. Increased hospital expansion and the establishment of some form of health insurance should make it possible for acutely ill patients to receive hospital care. The professional and non-professional worker must be adequately protected so that in the minds of the public there will be no confusion

between nursing needs and housekeeper shortage.

Turning now to the subject of preparation for the practical nurse. In Great Britain and in the United States the concensus amongst those who have been concerned with drafting legislation for the subsidiary worker would seem to be that training and experience should not be given in hospitals where a professional school of nursing already exists; that this training and experience might be given in hospitals that do not conduct a professional school of nursing, where such hospitals are willing to provide qualified classroom and ward teachers and adequate equipment for the classroom; but there seems to be general agreement that it would be more advisable to establish a central school for this purpose. Those who have had preparation for and experience in the field of nurse education admit quite frankly that it is most ill-advised to attempt to train two types of workers in the same institution.

Then, too, in some instances there might be a tendency on the part of the hospital to enrol student-subsidiary workers in large numbers without regard for a desirable ratio of supervisors to students, so that teaching and supervision might be negligible and patient well-being jeopardized. Added to this, large numbers of workers would be turned out yearly without any guarantee of placement. The hospitals might not be interested in these workers as soon as they were ready to be placed on a salary basis.

A central school for the training of subsidiary workers offers many advantages, some of which may be enumerated:

1. The development of standardized techniques built upon the principles which underlie good nursing care.

2. An opportunity to develop group ideals and good working relationships with other workers in the medical and nursing fields.

3. An awareness that the school is conducted primarily as an educational project and not as a means of providing direct hospital service.

4. Closer supervision of students and a better understanding of student needs.

5. Opportunities for developing the type of rotation in these hospitals selected for clinical experience according to the level of maturity and aptitude of the student.

6. An opportunity to assist the student, when she graduates, to find that particular field of activity, or type of work, for which she is best suited.

7. Greater opportunity for personnel work with the students.

8. The impartial reviewing of reports from hospitals providing clinical experience.

Clinical experience in general hospitals with an all graduate staff is desirable. In one province where an experiment in training practical nurses was carried out, several small rural hospitals were selected. The instructor, who had conducted the central school, arranged for and assigned the students for their clinical experience. She also carried out a supervisory program by paying periodic visits to each hospital where students had been placed. Conferences with the nursing staff and students were found to be mutually beneficial.

This type of experience may not be possible or practical in all situations. An alternative plan, which merits consideration, is that of utilizing convalescent hospitals, hospitals for the chronically ill, and last but by no means least, the tuberculosis sanatoria. The latter offers an excellent experience in medical nursing and, under normal conditions, the quality of nursing care given to patients in tuberculosis sanatoria is, in the opinion of those competent to judge, of a superior quality.

The areas of service for the practical nurse or trained worker include: (1) hospitals, sanatoria and nursing homes, under the direct supervision of registered nurses; (2) in private homes, where to a limited extent they may be under the supervision of visiting nurse

service, city and provincial nursing service, with all-over direction and supervision by a provincial supervisor appointed under legislation.

It is suggested that a record of service rendered and duties performed for the patient be kept by the licensed subsidiary worker and this record placed on file with the provincial supervisor as each assignment is completed. A similar record should be available from each type of hospital engaging licensed subsidiary workers.

While the licensing of these workers would be carried out by the agency vested with that authority, the registration and placement of these workers should be the responsibility of the nurse placement bureaux.

In conclusion, I will summarize the ideas presented by Miss Fidler in her paper on "The Preparation for Professional Nursing". She has suggested plans for the preparation of two types of professional nurse, plus the subsidiary nursing group:

The *clinical* or bedside nurse, who would be required to have Junior Matriculation and who, having been prepared in two years, would have professional status and be eligible for registration.

The *teaching* group who, being required to have Senior Matriculation, would be prepared in four years for more advanced service. This group would probably graduate with a degree in nursing.

I have, therefore, actually placed before you three types of nurses, all of whom would seem to be needed, if the nursing service requirements of the community as a whole are to be adequately met.

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# Pleased to Meet You

Perhaps every other professional group has as frequent meetings as we do but it is doubtful if any have more. Starting with staff conferences, nurses are continually either going to or just coming from a meeting. Autumn, winter and spring they assemble in committees, in local associations, in annual conventions. Most of the business at these meetings is conducted in quick order with very little dispute or controversy. Usually, the business session over, the nurses settle down in reasonable comfort to enjoy a guest speaker who brings them the latest word in new medical treatments, an educational symposium or plain, carefree entertainment. The high moment of the meeting, the release from tension comes when the redolent odour of coffee drifts over the assembly and refreshments are served. Then pent-up tongues which have been curiously hushed are busy in pleasant conversation. Nurses like meetings.

For six weeks this past spring, it was our privilege to attend a few dozen of those meetings in six provinces from the Pacific to the Atlantic. We were there as the guest speaker and on each occasion our talk was on the same topic — the *Journal* of the Canadian Nurses Association, of the nurses of Canada. The response to all of these numerous contacts was so heartening, so full of interest and resulted in so many new subscribers for the *Journal* it seemed appropriate to give a brief accounting in order that these scattered groups might realize the mutual pleasure so widely shared. Perhaps as never before hundreds upon hundreds of nurses in Canada realize that this magazine, *The Canadian Nurse*, is their personal responsibility. They know that it can only

be as good as the material that they prepare in the form of articles can make it. They understand that each has a share in interesting others in the *Journal*, to read, to criticize its contents, to help to make it the best nursing magazine it is possible to produce. For all of these contacts, for the splendid support which has been assured, our thanks.

There were several interesting features on the lighter side which deserve some special mention. Her embarrassment when the editor drew her own ticket at an alumnae raffle in British Columbia; the original tribute, beautifully penned as an illuminated address by a clever Sister in Saskatchewan; the fresh lobster on the half shell in Nova Scotia; the thrill of the swift progress from point to point by air travel; the beautiful corsages; the generous co-operation of provincial executive secretaries and *Canadian Nurse* conveners — all of these and many other incidents too numerous to mention made the trips memorable.

Many areas have not yet been visited. Plans are being made to attend as many as possible of the annual meetings of the Ontario district associations. Other areas will be visited as the occasions are presented. In the meantime, local representatives all over Canada are co-operating to make our *Journal, The Canadian Nurse*, worthy of its proud heritage. It was a pleasure to meet with so many, many nurses. Thank you for inviting us to come again.

—M.E.K.

## Treatment of Venereal Diseases Revolutionized

The newest development in the venereal disease control program lies in the rapid treatment of both gonorrhea and syphilis cases. The United States Public Health Service recommends that gonorrhea cases be hospitalized for twenty-one hours, treated with penicillin and released as cured.

In syphilis it is proposed to treat cases at the hospital for a period of eight days, following which they are released as cured with instructions for follow-up being given. It is proposed to combine the use of penicillin, arsenic and bismuth in this eight-day treatment. It is stated that this method is relatively non-toxic and causes few undesirable reactions. It seems to be the best method for the mass treatment of cases of early syphilis and its use has been recommended to various local health departments.

—*California's Health*

## National Immunization Week

*National Immunization Week*, sponsored by the Health League of Canada in co-operation with health departments, will be held this year from September 30 to October 6. The object of the week's observance is to draw attention to the fact that every Canadian child should be and can be protected against smallpox, diphtheria, whooping cough and scarlet fever.

In 1944 there were 3,211 cases of diphtheria and 13,382 cases of whooping cough. Dominion Bureau of Statistics 1944 fatality figures were incomplete at the time of writing, but for the first nine months of the year there were 168 deaths attributed to diphtheria and 209 to whooping cough. Thus it can readily be seen that this common disease of childhood is a killer.

Immunization against diphtheria can be obtained through use of harmless but effective toxoid.

—*Health League of Canada*

# PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

## The Future of the Nurse in Public Health

M. R. MACDONALD, M.D., D.P.H.

Today when social security is a very familiar topic of conversation for almost everyone, in almost every land, a person in the public health field would like very much to peer into the future and attempt to see just what developments in this particular field are going to take place. Great should be the results of all this invigorating interest in the social, health and welfare problems of our nation. I am sure most nurses would like to know the ultimate position of the nursing profession, in such a broad and challenging program.

Being unable to see the future, all we can do is attempt to envision it and conjecture as to the potential developments; that person who does not think that these developments are to be of major importance is indeed not very imaginative. The nursing profession will have to take bold steps and will have to take a very active part in this development if it is to maintain its position in the forefront of health activities. It must chart its course not as individuals but as an influential and capable body of professional workers whose responsibility is great.

In the public health field, the need for additional nurses is recognized under the present program, and how much greater will be the need in an expanded program? Public health activities to a large extent revolves about the public health nurses. The success or failure of programs may depend directly upon the nurses who are vested with the responsibility of doing the work in the field. For this reason, great care will have to be exercised in the selection, the training and the development of public health nurses.

Can the hospital of the future or its staff of nurses, or the private duty nurses remain aloof from these developments? Can they continue to leave the interest in work pertaining to the public health entirely in the hands of a comparatively small body of specialized workers? It is very doubtful. The field is large enough and important enough for the whole nursing profession and if expansion is to be of the magnitude envisioned by many today, then it will be very difficult for any nurse in any hospital or in private duty to remain aloof.

I envision the hospital of the future as a community health centre that will not only be responsible for therapeutic or curative medicine but will indeed pay as much attention to the preventive aspect of medicine. It is hardly conceivable that hospitals can remain behind in an expansive and popular program that has for its objective the maintenance of a positive health among the people of the community which it serves.

The position of a hospital in such a program will be only as good or as use-

ful as the interest and energy displayed in an expanding public health program by the superintendent and the nursing and medical staffs. It will behoove this personnel to acquire a broad and sympathetic understanding of the many and varied public health problems, because only if they are acquainted with the problems can they be of much practical use in the solving of them. Indeed at the present time many of the lay members of hospital boards are ahead of the medical and nursing personnel in their approach and their knowledge of problems that are receiving the attention of public health workers across Canada.

If the comparatively small band of public health nurses is to be augmented and increased in size, then it becomes part of the training hospitals' responsibilities to interest and teach the young nurses-in-training so that they will acquire a better and more complete understanding of public health work. This, of course, will be in contrast to present day standards where, at best, in the majority of teaching hospitals a smattering only of preventive medicine is provided the nurse during her period of training. To insure that the public health worker is competent and interested in her work, much will depend upon the direction and encouragement given her by those responsible for her nursing education.

The potential public health nurse will ask and will want a fairly complete picture of her duties and responsibilities as a public health nurse. Underpaid and overworked public health nursing staffs will not act as a drawing card for the recent graduate. They will have to be shown that they are not to be regarded as pioneers or crusaders to the degree that they were not so long ago and devote their time and talent to work which may or may not be appreciated. That day in public health is gone. The work must be made attractive and the volume of work should be no more than a person can handle with satisfaction, contentment and for a remuneration which will assure her of a standard of living comparable to the years of preparation and the maintenance of a status of life in the community that is expected of her. On the other hand, the nurse entering the field of public health should have an appreciation of what is expected of her. She should remember that public health still requires a lot of missionary zeal. She must remember that her responsibilities are great and that she has much to contribute to the success of any public health program. There is no place in the public health field for the shiftless, arrogant or selfish worker. As a part of an organization she must be able to assume her role working in unison and harmony with the other members of the organization. Her potentialities for contribution to the general welfare and success of a program are almost unlimited.

In earlier days of development of public health techniques, the public health nurse did "specialized work", that is, she confined her efforts to a limited field or to a single problem, such as tuberculosis. This did not prove to be satisfactory in the majority of places for a number of reasons. This led to a variety of nurses in a community doing specialized work and able only to devote their time to the particular problem to which they were assigned and in many cases they lost sight of the general picture. Also, patients and their families were subjected to the visits of several, rather than one nurse, and this proved to be a source of annoyance as well as being impractical.

Today we find the pendulum is swinging in the other direction and most nurses are doing a generalized service in public health. This tends to build up the confidence of the public in the nurse. Likewise, it reacts favourably for the nurses, as they have a more interesting variety of work and it makes the approach to a family much easier. Recently in the control of venereal diseases, specialized workers who have been des-

cribed as non-medical epidemiological workers have entered the public health field, and along with these non-medical workers have been nurses lacking a public health training, but with the few months training given to non-medical epidemiological workers. Our experience in this regard has been good and much excellent work has been done, but one wonders if this work could not be done by the nurse in the generalized field. Personally, I would say "yes". While the specialized worker may have or develop certain attributes which enable her to show a marked progress in her particular field, yet the determining factor is a question of time available to be devoted to a particular duty. The generalized public health nurses have a better and less auspicious approach to a family or person; they may go seeking or interviewing a person for a variety of reasons, but once the nurse in the specialized field undertakes to locate or interview a person, immediately eyes are lifted and opinions expressed. The "V.D. nurse" or the "TB nurse" was to see so and so.

Regarding special tact or diplomacy needed for venereal disease work — this I believe is a myth, and the farther we go in the control of these diseases, the more it will be proved to be so. Our nurses, like our doctors, and like the public in general, have been very reluctant to speak of syphilis or gonorrhea, or to have very much to do with persons afflicted with either disease. Once this barrier is broken down and greater progress is made, it is reasonable to assume that the generalized public health nurse, who has the necessary tact to make a good approach to a family regarding tuberculosis contacts or for other reasons, will be just as tactful and will have as good a method of approach in regard to the venereal diseases. Our nurses need to be educated regarding these diseases as much as other workers in the field. A complete understanding of the problem and its control or cure will serve to build up their confidence to the degree where venereal disease contacts are no more difficult to deal with than other persons requiring care.

The public health nurse is a health educator and is probably in the best position to do the educating. In order to be successful, much will depend upon her scholastic training, her hospital training and her public health training. In hospitals, particularly, I feel that nurses are not impressed sufficiently with the responsibilities which they should discharge once they are graduate nurses. Whether they later enter the public health field or not, they are health educators for the rest of their lives for, because they are nurses, people seek them out for information pertaining to health matters. If this information is given, but is not correct or is not explained fully, incalculable harm may be done, which reflects upon the nursing profession as a whole. It is far better for a nurse to refuse to answer questions than to give an answer that is incorrect or biased and to mislead people who readily accept her word as authoritative.

A recent innovation in the public health field is the "Health Educator" whose duty it is to direct and supervise the health education of the public. Whether this form of health education will prove to be practical or not is a moot question, but the public health nurse will remain alone as the person who is best able and is in the most desirable position to explain and demonstrate what is essential for the individual with whose care she is entrusted. The "Health Educator" may certainly occupy a role of supervision and direction of education.

In other fields, such as nutrition and physical fitness, private nurses and public health nurses will have to share a responsibility, if these programs are to be successful. In some instances it will mean no more than displaying an interest; in others it will mean taking an active part and the success or failure of such a program may very well depend upon the degree of acceptance and en-

thusiasm with which they are received by the great body of nurses.

With the forward march in "Social Legislation and Social Security", a greater liaison and a greater degree of co-operation between health and the different welfare agencies will have to be worked out, so that we will not revert to the old problem of duplication of visits. A whole program of social, health and welfare activities may very well fail because of the little things which will break down public confidence in our workers. An otherwise well-intentioned and efficient program may fail because of lack of co-ordination and direction.

Indeed the future will provide a challenge to the nursing profession, in active energy and interest will be needed, a broadening of viewpoints and a willingness to co-operate will have to be developed if nurses are to maintain the enviable position of esteem and respect in which they are rightly regarded by an appreciative public.

## Beware of Poison Ivy

Each year as amateur gardeners busy themselves in their vegetable or flower gardens, or as hikers or campers get out into the fields and woods, a fresh crop of suffe.ers from plant dermatoses develops. Symptoms may vary in degree from a mild erythema to a vesiculative dermatitis. The eruption usually occurs on the face but the neck, hands, ankles, knees and genitals may be affected. An acute dermatitis of the face, associated with marked edema of the eyes, usually indicates that the patient has been in contact with the oils, pollens or even the leaves of some plant. The dermatitis may last for several weeks, sometimes until the frost kills the offending plants.

Ivy poisoning is the most common form of plant dermatitis. The offending agent is a vine or low bush found widely throughout Canada, in moist soil and dry, in the woods and in open areas. It may be recognized by the three shiny, dark green tapering leaflets, by their reddish tinge in autumn and by the whitish waxy berries. Closely akin to the ivy is poison oak, the leaves of which are blunter, more rounded. Equally poisonous, is the poison sumac which grows in swampy places and can be distinguished from the harmless variety by the white berries instead of red and by the non-sticky fuzz covering the stems. Since it is estimated that one person in every eighteen is susceptible to the poisonous sap or oils which these plants exude, their immediate recognition is important.

The clinical picture most frequently seen is an acute vesicular dermatitis on the exposed areas of the skin chiefly, though the irritation may spread to any part. Intense itching and burning are common symptoms. Constitutional symptoms are seen in rare cases of great severity. The incubation period varies from twelve hours to seven days.

Those who have been exposed to this plant poison should take a hot bath immediately, lathering the body well with a rich suds to dissolve the oils. The nails should be scrubbed and thoroughly cleaned with an orangewood stick to remove every vestige of resin. All the clothing worn at the time of exposure should be dry cleaned. Soothing alkaline cold creams may be applied to the skin. Creams containing 10 per cent sodium perborate have been found useful as prophylactic agents. Sponging the areas with alcohol may also be effective.

When the eruption occurs, creams or ointments are contra-indicated since the resin is oil-soluble and the irritation may be further spread. In the acute inflammatory stage, continuous wet boric compresses or applications of 1:5000 potassium permanganate are soothing. After twenty-four hours calamine and zinc oxide lotion will bring relief, applied cold every hour, more often if necessary. In some cases, antigen injections may bring relief. The oily preparation of the antigen is less painful than the alcoholic but not so effective. Desensitization is problematical. The safest preventive is to know and avoid the offending agents.

# HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

## A Challenge to Head Nurses

FLORENCE M. WILSON

Gradually, in the field of nursing education, there has arisen a method of teaching student nurses known as clinical instruction. It is generally recognized that the word "clinical" refers to the patient — his disease, his treatment, his nursing care, or his prognosis, and thus in a school of nursing clinical teaching is the instruction of the student nurse with reference to the patient. In a slightly narrower sense, clinical teaching is carried out on the ward, in other words, while the student is caring for the patient.

Probably no one would deny the tremendous advantage to the student nurse, and ultimately to the patient, of organized ward teaching. However nurses who are not instructors are inclined to feel that teaching is a specialized branch of nursing which they know little or nothing about, and as a result they have decided to leave all the clinical teaching to the ward supervisor or the clinical instructor. This article is written for head nurses and general duty nurses in the earnest hope that it will awaken in them a realization of the fact that they are all indispensable to any ward teaching program.

To emphasize the value of clinical teaching, Wayland in "The Hospital Head Nurse" states: "No more dynamic and favorable learning situation is to be found in the total educational program than that offered by the actual care of patients, nor one that provides for more integrated learning. Without competent educational direction, however, the student in the midst of a wealth of learning opportunities may not 'see the woods for the trees', or she may be so driven to get the work done that she fails to learn from her experience. Clinical practice provides opportunities for learning the art of nursing, but the art will be learned only if good nursing is attentively and intelligently practised in the unit, and if the head nurse utilizes her unique opportunity of teaching the student, as she repeatedly and progressively practices not the manual processes alone, but the whole art of nursing."

The more organized forms of clinical teaching, such as the nursing clinic and the bedside demonstration, are generally recognized, but this article deals only with methods of clinical instruction which are going on all the time, but which are not recognized as formal instruction, and methods of teaching which could be used with very little adjustment in the daily routine. The following methods are included: precept and example; impromtu teaching; the orientation conference; the morning circle; the individual conference; supervision of procedures.

*Precept and Example*:

Every graduate nurse is a teacher

whether or not she wants to be or thinks she is. Think of the graduate nurse in a school of nursing — she is the goal toward which every student nurse is striving; she represents the ultimate, the ideal of accomplishment. All of us are inclined unconsciously to imitate those who are senior to us, and certainly much of what the student in the school of nursing learns, whether it is good or bad, she learns from the various graduate nurses with whom she works. Everything about the graduate nurse is closely scrutinized by the student nurse: her appearance, her methods of dealing with patients and personnel, and her nursing techniques, to mention a few. At all times this type of teaching of the student nurse is going on. We have all seen the transformation in quality of work done by a group of students when they are placed in a situation where the head nurse or another graduate nurse on the ward sets a splendid example for them. On the other hand, students in contact with a careless, muddling, or boisterous type of graduate nurse will develop many of her bad habits, and some of them will never lose those habits. Before any teaching in a school of nursing, be it classroom or ward teaching, is going to have a fair chance of producing the type of student nurse desired, it falls upon every graduate nurse in the institution to realize what an important part she is playing in the moulding of each student with whom she comes in contact.

*Impromptu teaching at the patient's bedside.*

*Impromtu Teaching*:

A second method of teaching which could go on most of the time on the ward may be called impromtu teaching. Wayland says: "Indeed, much of the most effective and worthwhile teaching in the whole school program is unhead nurse teaching." This type of teaching means exactly what the name implies — the situation arises, and the head nurse takes advantage of it to bring some point to the attention of the student. For example — what student would forget the symptoms and treatment of acute cardiac decompensation if someone took the time to do a little impromtu teaching while she was admitting the patient, and carrying out the doctor's first orders? Much impromtu teaching may be done at the patient's bedside while the student is giving bedside care — for example — assistance with the pillows of a patient who has had a thyroidectomy, or assistance in making a very ill patient comfortable.

A group of students may be taught in this way also. If an unusual situation suddenly arises on the ward, its significance may be lost to the students, if no one takes time to give them some explanation and direction in their observations. One of the best examples is the admission of a patient in diabetic coma. To wait two or three days before discussing such a patient with the students caring for him means that much of the value of that teaching situation has been lost, because by that time the patient will probably be up and around the ward, and the students will have forgotten a great deal about the picture he presented on admission.

There are two points about this type of teaching which should be stressed: First, the head nurse must be on the alert for such situations — many good opportunities are probably lost. Secondly, where impromptu teaching is done at the

patient's bedside, the student must not be made to feel that her work is being criticized, for she will immediately be on the defensive, which is a poor beginning for teaching. The teaching must be done in such a manner that the student feels she is being taught and not "snoopervised."

*The Orientation Conference*:

"The term 'to orient' means to get one's bearings, to see and understand relationships clearly." (Wayland).

The orientation conference should take place on the morning of the student's first day in the new department, and should occupy almost an hour. If possible, a group of students should be given this instruction at one time, thereby saving the head nurse's time. Actually orientation cannot be accomplished in one conference only, but will require three or four such periods during the student's first week on the ward. Although this type of teaching may appear to be very time-consuming, it pays dividends in that the student knows what she is doing, and understands her objectives much more clearly, and thus is able to render more satisfactory service; she will find her entire experience better from her own learning point of view.

The material discussed at the orientation conference would naturally vary with the experience of the individual student. In the main, such things as ward geography, ward routines, special treatments, and so on, are discussed. As part of the first conference, the new student is introduced to the other ward personnel, and to the patients she is to care for particularly, and is given detailed instructions about her own work. It seems advisable to leave a discussion of the diagnoses, etc., of all the patients on the ward to a second or third conference when the student has her bearings a little better.

The orientation conference should be conducted by the head nurse, because she, better than anyone else, knows all about her ward. In making a plea for adequate orientation to a department, one feels that many errors which a student makes are the result of her not knowing what she should have done because no one took the time to tell her, and much of the time she may waste is the result of not knowing where to find things or of not having been informed of ward practices.

*The morning circle.*

*The Morning Circle*:

Quoting from Jensen: "The daily morning conference, which all nurses, graduates and students, on any ward attend offers a great opportunity for teaching. It is the time when the night nurse in charge of the ward or division gives her report of all the patients' conditions during the night, so that the day staff may be prepared to give better nursing care."

This conference should take place at the beginning of the day, usually at 7 a.m., and should not last longer than fifteen to twenty minutes. The report is read to the group by the night nurse, during which time the head nurse should ask questions of interest to the group. Following the reading of the report there is a discussion on newly admitted patients, patients who are to have operations, special tests or treatments, and outstanding changes in patients' conditions, diets, etc. The head nurse may have some point of general interest to bring to the attention of the nursing staff

or occasionally she may use part of this period to draw to the attention of the nursing staff any laxity which their own work has shown. Nurses are always given an opportunity to ask questions during any part of this conference, and are encouraged to mention any points which are of interest to everyone. Following this discussion assignments of work are given and, where necessary, explanations are made.

The value of a properly conducted morning circle cannot be too greatly stressed. The nursing staff will have a greater interest in all the patients and will be able to start their day's work feeling that they understand what is going on.

*The Individual Conference*:

As the term implies, this type of teaching is a discussion between the head nurse and the student alone. It is absolutely essential during every student's experience in a department, and each student should have the privilege of several such conferences.

The general purpose of such a conference is to direct the student in her work, to find out her aims and ambitions, and to give her advice where necessary. To begin with, a good relationship must be established between the student and instructor, by keeping the discussion on the level of instruction rather than criticism, and by putting the student sufficiently at ease, so that she will not be embarrassed about showing her ignorance of the special problems of that ward. The discussion must be held in a place where there will be no interruption, and the length of time obviously would vary with the problem at hand.

*The orientation conference.*

Routine conferences which should be held with each student would be concerned with her progress in the department. A final conference would be helpful in summing up the type of work she has done, commending her where she has excelled, and directing her in solving any problems which she may have. Students who are consistently below average would probably have more individual conferences with the head nurse, who would do all possible to find out why the student's work was not acceptable, and thus attempt to improve its quality. Other students may have personal difficulties, or difficulties peculiar to that situation (e.g. O.R.) which an individual conference would do much to solve.

Those in charge of directing students in a department must make the student feel free to seek an interview. If at the time the student seeks advice the head nurse is busy, she should arrange another period which would be more suitable.

Wayland, in discussing supervision through individual conference, states: "For the head nurse, it is the moment of all moments at which she can learn most about the student and can exert her own personal influence upon the student's personal and professional growth to the fullest extent — a moment of great challenge to a real teacher. For the student, it is the moment when she is free to avail herself of the head nurse's help with the problems of learning and personal adjustment. The benefits to both head nurse and student will come about only if the student feels that the head nurse is sincere in her desire to help and is fair in her dealings."

*Supervision of Procedures*:

In most schools of nursing, the students are required to carry out some

procedures for the first time under supervision — for example — catheterization, hypodermic injection, vaginal douche, etc. The alert head nurse will be certain to make this a good learning experience for the student.

Before doing the procedure, the student should be required to review what teaching she previously has had on the subject — this would include definition, purposes, necessary articles, procedure, and precautions. Where necessary, the instructor will supplement the student's information.

During the actual carrying out of the procedure, the instructor should assist in such a manner that the student will carry out the procedure herself, but will be more at ease than would be the case if she were being closely scrutinized.

Following the procedure a short discussion is held on the type of work which the student has done, and any questions which she may have are answered.

As was stated in the beginning, this article has been written for graduate nurses working with student nurses in an effort to show how much influence they have on the type of learning which the student receives. Surely you will all agree with Anna Taylor that "ward instruction is basic if adequate nursing care is to be practised." An attempt has been made to show that there are certain means by which the graduates in a hospital may contribute to a student's learning experience, in fact are contributing at all times, even though they may not be part of the teaching staff. The contribution which they make is immeasurably important to the student nurse, the patient, and the smooth functioning of the entire institution.

It has been said that of all avenues open to the registered nurse, that of head nurseship is the most satisfying. To combine the satisfactory administration of a ward with the contribution to the education of student nurses is the task you have set yourself in becoming a head nurse. The challenge is there — seize the opportunity!

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## S.R.N.A. Handicraft and Play Therapy Exhibit

The handicraft and play therapy exhibit, prepared by Miss Grace Giles, created much interest at the recent annual meeting of the Saskatchewan Registered Nurses Association. Stimulated by such articles as "Necessary Ingredients", which appeared in the February issue of *The Canadian Nurse*, it was decided that the S.R.N.A. convention exhibit this year should centre around Handicrafts and Play Therapy for Children. A list of arts and hobbies was circularized among nurses and people interested in arts and crafts, inviting them to loan articles for the exhibit. The enthusiastic response resulted in a beautiful and interesting display of handicrafts.

In addition to lovely examples of all the commoner forms of handwork, there was weaving, leathercraft, doll furniture — delicate and complete to the smallest cushion, ornaments, wood carving, modelling, jewellery and ornaments of nuts, pine cones, felt and leather. A sewing basket woven from dyed wheat straw drew much admiration, as did the book-ends, vases, bowls and other pieces of pottery made from Saskatchewan clay. Under the caption "Book Repair", all the steps in rebinding used books were shown. Inner facings of birchbark and bindings of overalling were some of the unusual materials used for this work. In another section an intriguing little flowered hat reposed in its transparent hat box, made of old x-ray film. Beautiful lino-prints, colourful posters, soap carving, cunning rag-bag toys, with other articles too numerous to mention, made a unique display.

A very fine collection of stamps, samples of weaving and a handmade copper lampshade formed the contribution from one

nurse "on duty" in one of our smaller hospitals. In addition to seeing the possibilities of hobbies the nurses received information on where to obtain materials, patterns and directions, and approximate costs. A graduate nurse with years of experience in craft work gave an illustrated talk on several of the crafts represented.

One of the pleasantest incidents connected with the exhibit was the "preview" held for the Sanatorium patients on the evening before the convention. Patients were delighted to recognize work done in their own hospital and to gain a new idea of the many possibilities in handicrafts. There were even some who were wheeled about the tables on stretchers. An exquisitely modelled dog had come from the hands of a little Sister, whose face shone with happiness as her carriage was moved up and down the aisles.

It was not solely to introduce nurses to the joys of hobbies that the exhibit was planned. There is a real need for trained Occupational Therapists in our hospitals and to widen interest and increase understanding of the work, an additional display was arranged. The Canadian National Association of Occupational Therapists kindly loaned a number of posters and photographs describing and illustrating Occupational Therapy. The nurses were much interested and hope to promote the development of this important branch of therapy. An excellent article on "Occupational Therapy for Children" with some accompanying pictures from the Hospital for Sick Children, Toronto, was greatly appreciated.

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## Liven Up Your Meetings

Three very useful little books have been received recently. The first, "Planning your Meeting" by Ruth Haller, price 50 cents, discusses practical points to remember in preparing for various kinds of meetings. Such forms as panel discussions, symposia, round tables are explained very simply. Methods for "dressing up" meetings to give variety are outlined. The second handbook has the intriguing title of "How to Make a Speech and Enjoy It" by Helen Partridge, price 75 cents. So many nurses when asked to give a talk, shudder and get stage fright. "Treat your stage fright as the asset it is. Beforehand-nervousness charges your batteries. The more multitudinous your misgivings, the more you will be goaded into preparation and the better your speech will be". Explicit instructions are included on how to prepare the speech, what to wear, etc. The third booklet is a comprehensive outline of the "Rules of Order and Procedure for the Conduct of Public Meetings" by W. H. Fuller, price 15 cents. Here is parliamentary procedure in a nutshell. The officers and members of nurses' associations will find this information a valuable guide to the effective transaction of business.

The first two books may be procured from the National Publicity Council, 130 East 22nd St., New York City 10. The last booklet is published by N. A. MacEachern & Co. Ltd., 165 Elizabeth St., Toronto, Ont.

## Recreation Conscious

A nation virile and active has no place for disease and attendant miseries. A nation of individuals interested in organized recreational programs has neither the time nor the inclination to take paths which lead to unhappiness. Therefore, there appears to be a definite place in Canada's life for the National Physical Fitness Act which is aimed at the promotion of the health and happiness of all the nation's citizens. Also, it appears that establishment of a Division of Physical Fitness and Recreation in the Saskatchewan Department of Public Health probably is the most constructive step so far in any implementation of the national act.

This provincial department organized a Saskatchewan Recreational Movement (SRM) and lit a fire which, in the words of the movement's official publication, *Saskatchewan Recreation*, is "sweeping the province". SRM hopes to interest every village, town and city in helping promote social, cultural, and athletic activities, enterprises and events for the nearly nine hundred thousand men, women, and children of the prairie province.

The Saskatchewan movement is said by Major Ian Eisenhardt, national director of Physical Fitness, to be "the most advanced provincial proposal to date".

—*Health News Service.*

# GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

## A Word to the General Nursing Section

MABEL E. BROLIN

We are missing the boat . . . Having just returned from meeting nurses from all nursing groups, I realize with a pang that all is not well with our own particular group.

We are the backbone of the nursing profession — we are the ones to whom the ultimate privilege is granted, that of nursing back to health, with our own hands, another human being. Ours is the happiness of receiving the thanks of a grateful patient. We are the ones to whom the sick turn, in pain, in sorrow or in joy. In our hands, in a very large measure, lies the fate of each patient's recovery. We are the human link in a strange white world which guides them back from pain and from death. We are indispensable . . . yet for some strange reason we have allowed people to slip into the error of regarding ours as an inferior position in the nursing world. Stranger still, we are allowing ourselves to acquiesce in that thought. We seem to have adopted a chip on the shoulder attitude to the other branches of the profession, in a vain effort to combat what has become an inferiority complex.

Administration is a very necessary part of our profession. Without it our nursing world would be a chaos instead of the well run machine we have the right to demand in order to do our own best work. It is a different type of work, that is all, not a better one. The person fitted for that type of work needs perhaps, a different personality to be as successful in her place as you are in yours. We are component parts, and must co-operate to achieve a successful whole. Let us remember that and avoid dissension.

We must get ourselves back on the road to happiness and service. I would say the first step on that road is to ask ourselves if the work we are doing is the work that we wish to do. If it is not, by all means seek some other branch of the service. I believe the primary desire on first entering the profession is to give personal service, but by allowing our status to appear inferior in the eyes of our profession we are sometimes ashamed to admit that there is where our real interest lies.

If your real happiness in your work is in administering personally to the sick, then I would say — get behind your Section's activities. Then by precept, well-chosen leadership, and by fullest participation in post-graduate education in our own field, let us guide ourselves back to our place in the sun and convince the profession as a whole and the world at large that there may be different *branches* of service but none better.

# Postwar Planning Activities

**Contributed by**

**POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION**

## Re-establishment Information

Although many nursing sisters will have set aside their uniforms before this is published we think perhaps some of the information contained here may be of interest and help to many who still are in uniform. The April issue of the *Journal* carried some suggestions about the nursing positions waiting for the nurses. In the July issue is a list of the university courses, hospital post-graduate courses and added experience courses which you will find very useful should you wish to do a bit of studying or brushing up before seeking work.

In the brochure prepared for the nursing sisters we have made reference to the various Acts which have been passed by the Federal Government to aid in the re-establishment in civilian life of all armed service personnel, and we think that all should be familiar with the content of these Acts.

*The Post-Discharge Re-establishment Order* (P.C. 331, January, 1945). "University Education (Undergraduate): In case any discharged person (a) has been regularly admitted to a university before his discharge, and resumes within one year and three months after discharge a course, academic or professional, interrupted by his service, or (b) becomes regularly admitted to a university and commences any such course within one year and three months after his discharge; a grant may be paid to such discharged person for any period during which he pursues such course, upon the terms and subject to the conditions" of the Act.

"University Education (Post-Graduate): Where any discharged person resumes or commences a post-graduate course, either academic or professional, in a university within one year and three months after discharge, or commences such a course as soon as may be after completing an undergraduate course commenced or resumed by him after discharge, or where such person, on account of ill health or other reason satisfactory to the Department, delays resumption or commencement of such course beyond such periods, and the Department, having considered such person's attainments and his course, deems it in the public interest that such discharged person should pursue such course, a grant may be paid to him upon the terms and subject to the conditions" of the Act.

"The scale of grants provides for payments of $60 monthly to single men or women and $80 monthly to a man and his wife when the ex-service man or woman is taking training or completing education."

*The Veterans Insurance Act*, 1944. Parliament has enacted legislation providing government insurance for veterans on discharge:

"1. One of the principal features of War Veterans Insurance is that, with very few exceptions, it is available at low cost, without medical examination.

2. Any ex-service man or woman is eligible.

3. The plans of insurance available are 10-payment Life, 15-payment Life, 20-payment Life, Life paid-up at 65 and Life paid-up at 85. Term and Endowment policies are not issued. The

insurance is of the non-participating type, that is, no dividends are paid.

4. Policies may be applied for in amounts ranging from $500 to $10,000.

5. After premiums have been paid for two full years, the policy may be surrendered for its Cash Surrender Value. There is no provision for loans against the policy.

6. Where the insured is married, the beneficiary must be the wife or husband or children, or both. If the veteran is single, the beneficiary must be the future wife or husband, with a parent, brother or sister named as a contingent beneficiary to receive the insurance money should the veteran die unmarried.

7. In addition to being free of occupational restrictions, the insurance is also free of restriction as to travel and residence.

Further information may be obtained from the nearest office of the Department of Veterans Affairs or by writing direct to the Superintendent of Veterans Insurance, Department of Veterans Affairs, Ottawa."

*Reinstatement in Civil Employment Act*, 1942.

One of the first Acts placed on the statute books looking towards re-establishment was the Reinstatement in Civil Employment Act. The main points in the new Regulations may be summarized briefly thus:

In the case of a person who immediately after discharge is delayed in returning to his or her former employment by reason of hospitalization or physical incapacity, any period of hospital treatment or incapacity may be counted as continuity of service for seniority, pension, and so forth, in the same way as is the period in the Armed Forces under the Act. (Sec. 4).

Where an employer's business is carried on in more than one establishment, and where an employee cannot reasonably be reinstated in the particular establishment in which he was last employed, the employer is required to reinstate the applicant in one of his other establishments if it be reasonably practicable to do so, and if it has been the practice of the employer to transfer employees of the type of the applicant from one establishment to another (Sec. 6).

A person discharged from the Forces in Canada is allowed three months under the Act in which to claim his former employment—or four months if discharged overseas. The Regulations guarantee the applicant this interval between discharge and reinstatement, regardless of whether an employer may in the meantime offer the applicant an immediate return to his employment. It is felt that those discharged from the Forces may require a period of rest or re-orientation, and should be free to have this rather than be obliged to return immediately to employment upon notification from the employer. (Sec. 7).

A discharged person, who requires time to recuperate from a physical or mental disability before returning to work, will be allowed to claim reinstatement during an additional period of six months — in other words, such a person may claim reinstatement within nine months if discharged in Canada, or ten months if discharged overseas. The effect of this section will be to safeguard for this extra period the rights of a man who returns in a handicapped condition. (Sec. 9).

Where an employer claims (under Sec. 4 (e) of the Act) that an applicant is not eligible for reinstatement since he was employed to take the place of an employee who had previously entered the Forces, the employer must prove that the applicant was employed directly or indirectly to take the place of the other employee and would not have been employed if the other employee had not left. (Sec. 10).

The Minister of Veterans Affairs has issued a booklet entitled "Back to Civil Life" which contains many suggestions and facts concerning discharge proce-

dure. This booklet includes information on many of the following topics: rehabilitation, reinstatement, post discharge re-establishment, rates of grants, university education, unemployment insurance benefits, treatment branch, pensions commission, list of Veterans Welfare offices.

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# Book Reviews

**American Medical Practice in the Perspectives of a Century**, by Bernhard J. Stern, Ph.D. 159 pages. Published by The Commonwealth Fund, 41 East 57th St., New York 22. Price $1.50.

*Reviewed by Mary S. Mathewson, Assistant Director, McGill School for Graduate Nurses.*

This monograph is the first in a series of studies being undertaken by the Committee on Medicine and the Changing Order of the New York Academy of Medicine. The main purpose of the series is to investigate the economic and social changes taking place now and those likely to occur in the immediate future and the probable effect of these changes on the various branches of medicine. It is also concerned with the preservation of the best in the art and science of medicine and of medical service to the public as well as the search for new ways and means for improvement and adjustment to meet changing conditions.

The first volume presents a broad historical picture of the changes in social and economic life in the United States during the past century and their influence on the development of medicine. The topics discussed include the expansion of the medical horizon, development of specialties, patient load, income of physicians, distribution of medical services, and the effect on civilian services of the entry of enormous numbers of physicians into the armed forces.

This interpretation provides insight into the origin of current problems in medical education and medical service. Such a perspective is essential to an understanding of the present situation and as a basis for intelligent planning of future action. The story closely parallels the general development in this country and is interesting, therefore, to those who are concerned with the future of medicine and allied fields in Canada.

Future volumes will deal with hospitals, public health services, rural medicine, industrial medicine, prepayment and insurance plans, nursing, and dentistry.

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**The Woman Asks the Doctor**, by Emil Novak, M.D., F.A.C.S. 130 pages. Published by The Williams & Wilkins Co., Baltimore. Canadian agents: University of Toronto Press, Toronto. Price in Canada $2.00.

This small, compact volume of fifteen chapters, written in a clearly understandable style for the laywoman, contains the quieting answers to the many vague questions that continually arise in the minds of women of all ages.

The chapters on menstruation should be of particular interest and once and for all should clarify the confused ideas that exist regarding this female phenomenon. That part devoted to the "change of life" should be read by every woman if only to destroy the needless fears too often planted by well meaning and over eager friends. The sections on the reproductive organs and sex life of the female, written in non-technical terms, answer the many questions that doctors are continually faced with by their women patients. The vital difference between cancer and tumours is dealt with. The nurse realizes that, too often, these two conditions are regarded in a confused way as "practically the same thing".

This is an inexpensive book that the nurse could well profit by reading herself as well as recommending to her patients.

# Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

## Labour Relations Committee

In the report of the Labour Relations Committee submitted to the last meeting of the Executive Committee in October, 1944, the committee reported that its work was concerned with (1) methods of collective bargaining for nurses; (2) the relationship of nurses with trade unions; (3) interest in Dominion and Provincial labour department regulations that affect or may affect nurses.

### *Collective Bargaining for Nurses*

Since the last meeting of the Executive, further consideration was given to the resolution passed by the Executive Committee at their meeting in November, 1943, namely, "That the National and Provincial Associations should be the bargaining agent for nurses".

The Wartime Labour Regulations Act, P.C. 1003, which the Dominion Government passed by Order-in-Council in February, 1944, preserves for all employees the right to bargain collectively under certain prescribed conditions. These regulations, in common with most provincial legislation in reference to collective bargaining where such exists, state definitely that a bargaining agreement must be between employers and employees.

An employer is defined as a person employed in a confidential capacity, or one having the authority to employ or discharge employees. This raised the question — Could Provincial Nurses Associations which have an employer, employee membership, be the legal bargaining agent for nurses? As this question was subject to provincial interpretation, it was referred to the Provincial Associations for study with a strong recommendation that they secure legal advice.

In the majority of provinces, Provincial Labour Relations committees were set up and to date we have heard from six provinces, giving the following information: Five provinces — Nova Scotia, New Brunswick, Manitoba, Saskatchewan and Alberta — have secured legal advice and the decision has been either that it is not legally possible or not expedient for Provincial Nurses Associations to act as bargaining agents for nurses. Quebec is still exploring the possibility in relation to the Quebec Collective Agreement Act.

Contact was made with other professional groups, notably the Corporation of Professional Engineers. This organization, with other professional organizations combined under the name of the Canadian Association of Scientific Workers, explored, as reported in October, 1944, the possibility of securing separate legislation for professional workers in reference to collective bargaining. So far, this has not been granted and they report that the chances of obtaining such a separate code are very meagre.

The Canadian Association of Scientific Workers made an exhaustive survey of the possibility of their professional associations conducting bargaining negotiations for their members. The conclusion was that as all professional associations included in their membership, both employers and employees, they were unfit so to act. They then decided

that suitable employees organizations would have to be set up as separate new bodies, unaffiliated with any existing professional association or society. This has resulted in Quebec in the forming of the Quebec Federation of Professional Employees in Applied Science and Research, and in Ontario in a separate organization for professional engineers who are employees. The advisability of a separate provincial organization of nurse employees presents difficulties and dangers and is questioned by your Committee.

Consideration was given by the Labour Relations Committee of the Canadian Nurses Association to the possibility of joining with the professional groups, which asked for separate bargaining legislation for professional workers. This raised the question of the status of nurses. Is nursing a profession in the legal sense? This question was also referred to the Provincial Associations who again sought legal advice.

Nova Scotia was advised that members of the Registered Nurses Association enjoy the privileges and status of a profession, because they are so named in the Registered Nurses Association Act of 1931. New Brunswick reports that the Director of Labour states that the only phase of nursing that might possibly come under labour legislation is the Industrial Nurse. The controllers of industrial plants state that the nurse is a confidential employee and has the same status as a lawyer or minister. The status of the industrial nurse is now being argued upon by the New Brunswick Department of Labour. Manitoba's legal adviser states that in accordance with all legal interpretations of the definition of a profession in Canada and the United States, nursing is now a profession. Alberta reports that the Registered Nurses Act of 1941 falls short of establishing nursing as a profession inasmuch as it does not legally constitute membership in the Association, a condition precedent to the practice of nursing. Saskatchewan reports that, on the advice of their legal adviser, it is not considered advisable at the present time to seek further interpretation of the status of nursing in that province.

Due to the conflicting interpretations of the status of nursing as a profession and with the advice of our legal adviser, the Canadian Nurses Association did not join with the other professional groups in their efforts to secure a separate code governing collective bargaining for professional workers. The Committee, therefore, felt that if it is not legally possible for their Provincial Associations, in the majority of Provinces, to act as bargaining agents for nurses, that a modified resolution should be considered by the Executive Committee to replace the resolution of November, 1943, and that some other method of collective bargaining for nurses be devised by which this responsibility can be kept within the professional group.

The Labour Relations Committee invited Miss Margaret Mackintosh, Chief of the Division of Labour Legislation, Dominion Department of Labour, to meet with the Committee on May 15, 1945. Miss Mackintosh substantiated the opinion received from the five provinces that the Provincial Registered Nurses Associations could not act as bargaining agents. Arising out of information submitted by Manitoba and Alberta, the following recommendation was the result of this meeting:

> That the National Committee on Labour Relations advise the Executive Committee that we suggest to the Provincial Associations that they consider the following plan:
>
> That the local or district organization of the Provincial Registered Nurses Association select three or more *employee members,* who would inform themselves on Labour conditions in their locality and be prepared to act, if asked, as a certifiable negotiating or bargaining group, either with or without representatives from the nurse employees affected in any disagreement.

Miss Mackintosh feels that the certi-

fied bargaining group should be chosen locally for their interest in and knowledge of local conditions. Whether this negotiating group would act as members of the local or district association, or as interested individuals in their personal capacity, would depend upon the legal interpretation in each province. It would seem from the legal advice received from Alberta that they might act as members of their Association, but in Manitoba, they would act as individuals in their personal capacity.

It is further suggested that each Provincial Association have an active Labour Relations Committee, *as distinct from their Legislation Committee*, but have an interlocking membership, especially applied to the two conveners. That this provincial Labour Relations Committee, with the approval of the Executive Committee or Board of Management, be prepared to act with the certified negotiating group in an advisory capacity, in order to add the influence of the Provincial Association to the bargaining group.

That the National Labour Relations Committee with the approval of the National Executive Committee be prepared, if asked by the provincial Executive, to act in an advisory capacity with the provincial Labour Relations Committee and the certified negotiating group, provided the agreement contemplated is of major importance, and the added influence of the National Association would be of value.

It should be *clearly* understood that this advisory assistance would be available, only if the agreement contemplated has the approval of the Provincial Association and, if required, of the National Association.

While this type of organization seems somewhat involved, it would provide, within the professional nursing group, means through which the members of the Provincial Association could look to their own Association for assistance, in their collective bargaining agreements. Its possible success would depend on the willingness of the dissatisfied nurses to call upon the personnel selected as the negotiators.

*Trade Unions*

The question as to whether professional registered nurses should become members of Trade Unions is a matter of grave concern.

The thinking of the Labour Relations Committee is, that solely for the purpose of collective bargaining, they should not. We do, however, think that we should have a tolerant and questioning attitude toward the type of organization which, in spite of all the criticism that can be brought against it, has resulted in improving the working and living conditions of millions of our fellow citizens during the last century.

The groups of nurses most likely to become involved in the question of affiliation with Trade Unions, at the present time, are nurses employed in provincial and civic departments of health and nurses in hospitals where there are employees associations. Nurses in industry may also be affected. The present practice is as divergent as the opinion in reference to the professional status of nurses. Nurses in the Department of Health in Calgary state that the only bargaining agent the City Council will recognize is "The Civic Federation of Employees", which is affiliated with a labour union. Until recently the public health nurses were not members of this group. They were dissatisfied with their salary schedule, but could get no action. At the request of the sanitary inspectors, the public health nurses, dentists and clerical workers of the Health Department decided to form a separate Local. One hundred percent of the nursing staff are in favour of joining. Dr. Hill, the M.O.H., and the heads of the Civic Federation approve. This Health Department Local is affiliated with the Civic Federation of Employees and with the Trades and Labour Council.

In Toronto, the nurses of the De-

partment of Public Health are considering joining (if they have not already joined) the Toronto Municipal Employees Association, Local 79, of the A. F. of L. affiliated with the Trades and Labour Congress. The nurses are stressing "What nurses can contribute to union organization rather than the benefits they may derive". Three physicians of the Department and the social workers of the welfare Division are already members of the union organization. The dental staff were considering the matter at the time of writing. The nurses, and I think the social workers, have a definite agreement in writing with the Trades and Labour Congress that they would not be expected to strike. The Trades and Labour Congress stated in writing that for the last three years they have been on record as favouring a "No strike policy" for nurses and for professional workers in essential services. Insofar as the National Labour Relations Committee has information, other groups of nurses affiliated or that have been asked to affiliate with Trade Unions are nurses employed as civil servants by the Provincial Government of Saskatchewan, and nurses of the Department of Health, Montreal, Saskatoon, Regina and Moose Jaw. Our information states that some nurses have already joined, but is not clear as to the position of the groups as a whole. Nurses on the staff of the Civic Hospital in Saint John, New Brunswick, through their Employees Association, are affiliated with the Trades and Labour Congress of Canada.

While we know that some industrial nurses have joined the union, favoured by the plant in which they work, we have not the information on record. The information we have shows the trend toward Trade Union participation by nurses. For public health nurses and social workers, the effect of whose service is so dependent on the financial ability of families to maintain a decent standard of living, this trend is quite understandable.

These experiments in Union Association have value for Canadian nurses as a whole. We can only learn from experience, but we must move slowly.

*Other Dominion and Provincial Labour Legislation that Affects or may Affect Nurses:*

*Unemployment Insurance*

The Alberta Labour Relations Committee has asked for information as to whether all graduate registered nurses, regardless of position, come under "The Unemployment Insurance Act of 1940". Nursing under this Act is an excepted employment. The Act states, under excepted employment:

> Employment in a hospital or in a charitable institution where in the opinion of the Commission such hospital or charitable institution is not carried on for the purpose of gain.
>
> Employment as a professional nurse for the sick or as a probationer undergoing training for employment as such nurse.
>
> Employment at a rate of remuneration exceeding in value two thousand dollars a year is also excepted.

Whether or not nurses may wish to come under unemployment insurance is a matter for consideration.

*Minimum Wage Legislation*

While in most provinces this type of legislation does not affect professional nurses, it should be watched carefully by each province.

*Wage Control Orders*

At the time of submitting the report of this committee at the biennial meeting in Winnipeg, it was not thought that this type of legislation could affect nurses. It is now reported that in February, 1945, the salaries of nurses in doctors' offices in Lethbridge, Alberta, were by order of the War Labour Board reduced from $115 to $100 a month for senior nurses and set at $80 per month for new employees. The salary of an untrained receptionist was set at $90. While this is a provincial matter, your committee has asked Miss Mackintosh to give us advice on this ruling.

*Workmen's Compensation Act*

There is considerable divergence in the practice of hospitals and organizations as to whether nurse employees are included under these Acts. As this again is provincial legislation, it should be considered by the provincial Labour Relations Committees.

With the end of the war in Europe, and possible changes in both Dominion and Provincial Government administration, there will no doubt be changes in Labour Legislation. We must keep ourselves informed of such changes as they affect the nursing profession.

ESTHER M. BEITH

*Convener, Labour Relations Committee*
*Canadian Nurses Association*

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# Through the Years

E. FRANCES UPTON

In December last, when plans were launched for the celebration of our twenty-fifth anniversary, I was asked to prepare a brief history of those years. I accepted the honour very reluctantly, feeling in my bones, that, apart from the fact that I possess no particular ability to write things, to complete this assignment on time was a physical impossibility. However the story has been written. I might call it "an experiment in mutual understanding". I choose that title because I have always believed that that is exactly what our Association stands for and, having been closely associated with its work and development for sixty-four percent of its lifetime I am beginning to believe that the experiment could work if the one and only thing which retards its progress were removed. That weakness is, and I say this with sincere apology to the Hon. Winston Churchill, "So much is expected by so many of so few".

Towards the end of the first world war, when events similar to those which we have experienced since September, 1939, persuaded nurses to pool their resources and work for a common cause and aim, a small group of leaders in nursing in Montreal brought into being The Graduate Nurses Association of the Province of Quebec which had for its main objective "The improvement of the lot of the smaller school", the securing of legislation to establish standards in preparation for nursing services being, of course, the idea in the back of their minds. For three years this little group laid the foundation for the society whose twenty-fifth anniversary we have been celebrating and to whom much of the success attained is due.

Their first meeting was held on July 9, 1917, in Montreal when Miss Grace M. Fairley was appointed president and Miss Mabel F. Hersey, honourary secretary. Miss Fairley continued in office for two years resigning when she left Montreal. Miss Hersey carried on and formed the bulwark around which the whole structure developed.

During their first annual meeting held on September 16, 1918, reports indicated that "a proposed bill to provide for the legislation of nurses had been drawn up and fully discussed, amendments made and the final draft forwarded to the Association's legal adviser, a copy having been sent to the Montreal Medico-Chirurgical Society for approval, criticism and support". Miss Jean Gunn, president of the "Canadian National Association of

Trained Nurses", later known as the Canadian Nurses Association, was guest speaker, her address being "The Value of Centralization of Teaching".

Fifteen English-speaking nurses, whose names are listed in the minutes, six from Hôtel-Dieu and three sisters from Hôpital Notre Dame constituted the audience upon that historical occasion.

The Committee was re-elected and plans were laid to approach the V.O.N. regarding "the possibility of recognized training schools sending their pupils for a two-months course in V.O.N. work in order that our pupil nurses might learn how to teach hygienic living". *That was in September*, 1918.

Space will not permit me to enumerate the steps taken and the opposition encountered. Suffice it to say that this indomitable and courageous group reached its objective and on February 14, 1920, the Lieutenant Governor of the province signed their bill which provided the State's recognition of graduates in nursing in this province, and created the Association of those so qualified. It is a significant fact that growth cannot take place in any institution without an organization in which the people concerned can come to some agreement as to their goals or objectives. Until we have unity of purpose among individuals, growth in terms of improvement cannot be achieved. These leaders of ours, conscious that the advancement of nursing could only be accomplished by greater unity of purpose and understanding and, in a sincere endeavour to improve existting conditions, secured the one instrument which provided the first step in that endeavour, namely *Registration.*

The objectives of our Association since that day in 1920 have been threefold and all inclusive. They are:

To provide a body of fully qualified and competent nurses for the care of the sick, to provide means whereby those who possess such competency and training may be made known to the public and also to promote the efficiency, usefulness and welfare of nurses generally.

That has been for twenty-five years and still is, "our task" — 'tis a heavy one and requires the individual effort of each one of us.

Provided with the tools, and armed with a goodly supply of human wisdom and understanding, the great work began and continued on a voluntary basis for the first five years. Only another group of women might match that for courage and determination. How many of you know that during the first year Miss Hersey and Mlle Guillemette acted as Registrar, in addition to their full-time jobs, during which time they registered 1,415 nurses. As soon as R. N. certificates made their appearance, opposition began to develop and in 1922, in order to avert disaster, a compromise was made through Act amendment. We will not dwell upon the effects of this first rebuff because such difficulties have long since been removed.

The early development of the organization was greatly aided by the facilities and opportunities afforded through the schools for graduate nurses established at McGill and the University of Montreal. Refresher courses were conducted under Association auspices and scholarships were provided for members wishing to avail themselves of these new and excellent opportunities.

With the formation of sections, of service groups and special committees, our relationship with our confreres in the other Canadian provinces, the United States and the world at large was firmly established and has developed and prospered to the extent of our contributions to the common cause.

In keeping with the progress of the times our standards were raised in 1925,

(*Concluded on page* 646)

# Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

## The Past and the Future

The war is not over, and there is still much emergency nursing to be done; but the end is in sight, and our planning now must be for the future. At this transitional point, we naturally pause for a moment to ask ourselves what has been done in Canadian nursing during six years of war, and what suggestions this experience holds for the future. What permanent benefits might accrue from the experience? What lessons can be learned for nursing education? What are the matters that have emerged to claim the attention of the Canadian Nurses Association and the Committee on Nursing Education, and what will be their place in the future of Canadian nursing?

One of the great landmarks was the Government Grant — the grant by the Federal Government to the Canadian Nurses Association, to be used for educational purposes, with the primary objective of producing more well qualified nurses. This naturally suggests the possibility of grants from the provincial governments. It raises also for the careful consideration of all nurses the whole question of responsibility for and control of nursing education. On the one hand we are told that nursing education, like all other education, is the responsibility of the state; on the other, we are warned to beware of bureaucratic control. Does the one necessarily imply the other? These are not simple questions, but it will be observed that in this country the Government Grant was made outright to the professional association and, within the broadly stated purposes for which it was made, was controlled and disbursed entirely by the Association.

Another question which arose early in the war was that of accelerating the basic educational program. The Education Committee was asked to prepare a plan for this, and outlined a course by which students would be available for service in two and a half years. As far as we know, this plan has been used by one school only. Much nursing opinion has felt strongly that while there were far more applications for the armed services than were accepted, and while large numbers of nurses continued on private duty registries and refused, and were not officially required, to do general duty in hospitals, telescoping of the basic training to meet service ends was quite unjustified. This may be true. On the other hand, it does not dipose of the fundamental problem of whether the traditional three years is, in fact, the optimum period for basic training in bedside nursing.

A large number of nursing auxiliaries, voluntary and paid, military and civilian, have received varying degrees of training and have participated in nursing during the war. Where does this lead? Will many wish to continue in nursing? Is there a need for their services? What of their further training, conditions of work, the control of their practice?

Many returning members of the women's services are interested in professional nursing and are eligible for nursing schools. Among the questions raised in this connection is that of how such a prospective student will select a nursing

school. The Executive Committee of the Canadian Nurses Association has referred the matter of the accreditation of nursing schools to the Committee on Nursing Education for study and recommendation.

Finally, there still remain on the agenda the questions of a Canadian Nurses Association First Aid qualification for nurses, and of the second type of professional nurse.

These, then, are the problems which will occupy the immediate attention of the Committee on Nursing Education, and on which all Canadian nurses should be thinking with them.

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## Through the Years

(*Concluded from page* 644)

by Act amendments, which more fully described an approved school of nursing and set examinations as a requirement for registration. The work carried out by our Boards of Examiners from that time merits the highest possible praise and appreciation.

Delegates of both language groups have represented us at all conventions of our national association held through the years and have carried our voice across the seas in 1933 and 1937, when they shared the experience of the congresses of the International Council of Nurses. We have been privileged to have been hostess group to the Canadian Nurses Association upon two occasions and will never forget the thrills we experienced when we helped to steer the sixth Quadriennial Congress of the International Council of Nurses held in Montreal in July, 1929. Registration at that time indicated the largest convention ever held here. Yes! Verily! we shall never forget that experience.

When our country declared war in September, 1939, we immediately took stock of our resources and found the names of one thousand of our members on the voluntary enrolment for national emergency — that thousand and many more were available immediately. The preparation of instructors in First Aid was organized at once, to be followed by lectures and demonstrations in air raid precautions and the results of gas attack. Thousands of our members have shared this valuable knowledge and the modern teaching of First Aid has been included in our school curriculum. Now that victory in Europe has been won, our special committees, appointed for the purpose of assisting in post-war planning and the rehabilitation of service personnel, are ready and alert to guide our endeavours, in relation to our responsibility towards other groups with similar aims and interests.

Where are we? What are we doing today? Fourteen thousand, five hundred and eleven have been received into membership during the years under review, 5,058 on training alone, 8,483 on training plus special examination and 970 by reciprocity. Our requests for reciprocity have involved a study of the nursing laws in all the Canadian provinces, most of the States in the U.S.A., Australia, England, Scotland, Norway, Denmark, France, Finland, Holland and Sweden.

In conclusion may I suggest that we remember and honour that little band of pilgrims who, having contributed to the organization and development of our Association, are now numbered among the "Saints who from their labours rest". To the grateful memory of Mary Shaw Barrow, Louise Bérubé, Huberta Chagnon, Mabel Clint, Louisa Dickson, Sister Fafard, Mabel Hersey, Mother Mailloux, Lillian Phillips, Mary Samuel, Ethel Sharpe, Flora Madeline Shaw, Nora Tedford, Zaidee Young, Christina Watling.

# STUDENT NURSES PAGE

## Advice of One Student to Another

BRIDGET MULLIGAN

*Student Nurse*

*School of Nursing, Misericordia Hospital, Edmonton.*

Dear Elizabeth:

So you are discouraged! Being a student myself, and moreover your best friend, you will permit me, won't you, to give you a helping hand? I know what you are going through. I understand your feelings for they were mine one day.

It was only four months ago that you bade your family and friends good-bye, and boarded the train to begin your new career. When you first arrived in the city do you remember how it fascinated and excited you? The first week in the residence was just what you had expected — every one was so helpful and considerate. However it does not take long, unfortunately, for "cliques" to form. Clothes, personalities, hobbies and manners make fissures too great for the average young person to span. You kept wishfully thinking that you would become adjusted in time without any conscious effort on your part, and all the while the entire situation was undermining your self-confidence.

The first day you went on the floors you just knew you couldn't do as well as Mary, because she had wit and personality. Everyone said so. Betty's hair and clothes were always in such perfect order. Doreen could sing like a bird and play the piano too. Seriously now, Elizabeth, can you tell me what real difference wit and musical talent makes to people when they need nursing care? As for clothes, we are all offered the same chances to look neat and trim in our uniforms.

These were the things that really mattered to you that first morning. It would not have been surprising had you spilled a tray, dropped a wash basin, or knocked over a screen. Head nurses and seniors can loom as insurmountable hurdles to a mere preliminary student and that is just what they were to you. Gradually you began to feel that you were being singled out as a target for their wrath. Each day added more depth to the already overwhelming whirlpool of discouragement that was steadily engulfing you. Finally you gave up even trying to study for examinations; doubt and fear of failure had set in. You had no one to turn to for that extra pat of encouragement that means so much. So you groped about, not realizing that the required strength must come from within.

You need not be discouraged, nor need you fear failure, for success is primarily a state of the mind. If one feels one is a success that is the first step toward the goal. You say you like nursing more than anything else, and yet you are willing to hand in your books and uniforms and quit! That sounds a

bit unreasonable to me, wanting something so badly but walking out on it because you think you are a failure. It leaves you with a feeling of disappointment, mostly with yourself, doesn't it? In some cases confidence in oneself might be "false pride", but not so in your case. Anyone who has passed the rigid entrance qualifications which a student nurse must, should never allow the word failure to cast a shadow over her training days. The diploma which entitled you to enter the school of nursing, should also give you the inspiration and confidence you need in your theory. Next to confidence as a requisite to success comes determination. Few people realize how essential just a bit of "old-fashioned spunk" is. It is that quality which forces us to keep practising even if our first attempt at bandaging was bad. It is that inner voice that urges us on — tomorrow will be better. Determination is not a native quality; it is a long and steady process, a day-by-day building. So you see you are offered the same chance for success as your classmates, bearing in mind that you must have confidence and determination. Take stock of your outward appearance. Choose your ideal type of a nurse and never let her image fade from mind.

Another requisite for success is the thirst for knowledge. It is an inner urge and must not only be present through the three years of training, but all through one's life. It must make a nurse desire a thorough understanding of her own daily work, and also of the new and many vast fields in science and medicine that are opening up to her. A nurse must remember that she is a pillar of strength to those around her. She is the only contact with the outside world that some of her patients have. Therefore she cannot for a fleeting second let her confidence fail her, lest her patients feel that she is at loss for a solution to their problems. A patient will never quite trust a nurse again who has betrayed this confidence.

Being a good nurse is the same as being a renowned musician or a famous athlete. These people do not learn their skill in a day. They practise daily, and so must the nurse. Each day brings something new and interesting. However, understanding must come first — for without knowledge of what one is attempting to do, practise would prove useless.

From all this, Elizabeth, you will gather that I am not urging you to stick with nursing as a three-year course; I feel it is a life work. In any career one must accept the dark days with the bright ones; similarly, in nursing. The nurse not only serves humanity, which in its pettiness may remember or forget her, but she is constantly serving God, who never forgets even the smallest of her hardships. To me nurses have a distinct advantage over people of other professions. There is such a wealth of satisfaction to be derived from the smallest task in nursing. Just a simple "thank you" from some aged woman to whom she has given a drink, or just the smile of gratitude in the eyes of some suffering young patient can make a nurse's spirits soar to heights unknown to the average work-a-day world. In a nurse's life there is such a close association of sorrow and happiness, of life and death, that some religious life is necessary. It is this gentle tone which helps to blend all other qualities of a nurse into an admirable character.

So, Elizabeth, square your shoulders just a little bit more, as you pin on your bib and apron tomorrow morning. Tilt your chin just a little higher as you put on your cap, and smile just a little oftener as you begin on your renewed attempt at being a successful nurse. You can do it.

*Sincerely yours,*

EVELYN.

## Manitoba Student Nurses' Association

Despite the many "growing pains" of our new Association, it is felt that all members have derived benefit from our meetings. They have broadened our outlook on nursing and have made us realize that nurses everywhere have common problems. Each of us has enlarged her circle of friendships. The Association has broadened the outlook on student life for many of us. We have actually seen many fine things that other training schools are doing, and this makes us aspire to better things — for example — the St. Boniface Hospital Student Dramatic Club and the Winnipeg General Hospital Record Night.

It has brought us all in closer touch with the M.A.R.N., what it can do for us, what we can do for it. We will be better M.A.R.N. members for having been members of our M.S.N.A.

DOROTHY MARSHALL
*Past President, M.S.N.A.*

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## Valuable Chemical Harvested from Lake

Crystal-covered lakes dotted across the Canadian prairies yield each year an unusual and valuable harvest of a widely used chemical compound, sodium sulphate.

When investigation of the deposits in White Shore Lake, near Palo, Saskatchewan, was first undertaken by Canada's Department of Mines, it was estimated that approximately 19,760,000 tons of hydrous salts existed in the lake in deposits varying in depth from three to seven or more feet.

Tens of thousands of tons of the dehydrated crystal, known to the trade as "salt cake", are required each year in the manufacture of kraft paper. Canada's glass industry also uses the chemical and large tonnages are required in the smelting of nickel and copper ores and in various branches of the chemical industry.

In the late summer and in dry seasons, the lake becomes a huge deposit of crystallized salts. These deposits are harvested by scrapers and fleets of trucks which pile up huge reserve stocks.

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## Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

*Mary Bastedo* and *Winnifred Tredaway*, who have been on leave of absence with scholarships from the V.O.N., having completed their course in public health nursing, have been posted to the staffs in Brantford and North York (Ontario) respectively. *Marguerite Ries*, having completed her course in public health nursing at the University of B. C., has been appointed to the Gananoque staff.

*Margaret Baker* (Vancouver General Hospital and public health nursing course, University of B.C.) has been appointed to the Burnaby staff. *Isabel Barron* (St. Joseph's Hospital, Winnipeg, and public health nursing course, University of Toronto) has been appointed to the Winnipeg staff. *Beryl Crawford* (St. Joseph's Hospital, London, and public health nursing course, University of Western Ontario) has been appointed to the Waterloo staff.

The following nurses have been appointed to the Toronto staff: *Bernice Bannister* and *Frances Y. Carroll* (Brantford General Hospital) and *Marion A. Hatcher* (Royal Victoria Hospital, Montreal). All have taken the public health nursing course at the University of Toronto. *Dorothy Wyeth* (Victoria Hospital, London; B.Sc.N., University of Western Ontario) has been appointed to the Border Cities staff.

*Louise Steele* has resigned as nurse-in-charge of the London Branch to accept a position with the Ontario Provincial Department of Health. *Ellen Holland* has resigned from the York Township staff to be married.

## M.L.I.C. Nursing Service

*Monette Gervais* (St. Françoise d'Assise Hospital, Quebec City) has completed the public health nursing course at the University of Montreal and will return shortly to the Mount Royal Nursing Staff.

*Jeannine Coupal* (Ottawa General Hospital and public health nursing course, McGill School for Graduate Nurses) recently resigned from the Company's service. Before joining the R.C.A.F. in January, 1942, Miss Coupal was nurse-in-charge at Chicoutimi, P.Q.

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## Ontario Public Health Nursing Service

*Irene Weirs* (Wellesley Hospital, Toronto, and University of Toronto public health nursing course), who has been until recently the public health nursing supervisor at Fort William, has accepted the appointment as supervisor of the Welland-Crowland Unit.

The following graduates of the public health nursing course at the University of Toronto have accepted appointments: *Mildred Laughlen* (Belleville General Hospital) with the North Bay Board of Heath; *Elizabeth Pike* (Toronto General Hospital) with the Welland-Crowland Health Unit; *Margaret MacMackon* (Royal Victoria Hospital, Barrie) with the Kirkland-Larder Lake Health Unit; *Ethel Rutledge* (Kingston General Hospital) with the Guelph Health Department; *Barbara Wood* (Kingston General Hospital) with the Hamilton Department of Health.

The following graduates of the University of Western Ontario public health nursing course have accepted appointments: *Irene McCarty* (Ontario Hospital, London) with the Welland-Crowland Health Unit; *Elizabeth Skinner* (Stratford General Hospital), with the Port Arthur Department of Health; *Georgina Harrington* (Ontario Hospital, London) with the Middlesex County School Health Unit.

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## Saskatchewan Public Health Nursing Service

*Doris Corcoran* (Holy Cross Hospital, Calgary) and *Genevieve Matheson* (General Hospital, Port Arthur), who have recently joined the staff, have taken up their duties in the Assiniboia West and Shaunavon South districts respectively.

*Sara Bayard* and *Roberta Cornelius* (Regina General Hospital), who joined the staff at the beginning of the year, are working in the Regina and Kerrobert districts.

*Louise Miner*, the most recent appointment to the staff, completed the University of Toronto public health course in May.

*Marion Douglas* of the Kindersley district has resigned to be married.

*Marjorie Leger*, *Edna Moore* and *Blanche Treble*, who have recently returned from University, have gone to the districts of Wynyard, Preeceville and Maple Creek, respectively.

*Evelyn Boyko* transferred recently to the Tisdale District.

*Mrs. H. A. Fletcher*, who has been working in the Tisdale district, transferred to the Estevan Larger School Unit. In addition to a generalized program of public health nursing, Mrs. Fletcher will carry on a special health education program in the schools of the unit.

*Lorena McColl*, North Battleford, took part in the program of the annual S.R.N.A. convention, speaking on the subject, "How *The Canadian Nurse* has helped the public health nurse".

# What is "Acid-Moisture"?

## How Z. B. T. Baby Powder Helps to Resist Moisture Dermatitis in Infants

Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content ($C_5H_4N_4O_3$), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia ($NH_3$).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

**Z. B. T.—the only baby powder made with olive oil**

## R.C.A.F. Nursing Service

The Director of Medical Services (Air) announces the following promotions and changes which have recently taken place in the R.C.A.F. Nursing Service:

A/Matron *A. H. Nelles* (Hospital for Sick Children, Toronto), has recently received her promotion and is on duty at the R.C.A.F. Hospital, St. Thomas.

N/S *D. C. (Pitkethly) Lindsay* (Ottawa Civic Hospital) was awarded the A.R.R.C. in the King's Birthday List. She was with the Mobile Field Unit Overseas and was one of the first nursing sisters to land on the continent following D-Day.

N/S *N. M. (Chittim) Trotter* (General Hospital, Chatham) was awarded the A.R.R.C. in the King's Birthday List for valuable service. N/S Trotter is at present on duty at R.C.A.F. Headquarters, Ottawa.

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## Royal Canadian Naval Nursing Service

The following nurses received honours in the King's Birthday Honours List:

*R.R.C.*: P/M *A. R. Fellowes* (Royal Victoria Hospital, Montreal); P/M *F. M. Roach* (St. Michael's Hospital, Toronto).

*A.R.R.C.*: Matron *C. A. Evans* (Victoria Hospital, London): N/S *M. I. Green* (Toronto General Hospital).

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# NEWS NOTES

### ALBERTA

EDMONTON:

*Royal Alexandra Hospital*:

Three graduates of the Royal Alexandra Hospital School of Nursing have recently been awarded scholarships and will take university post-graduate courses this autumn. The R.A.H. Alumnae scholarship was awarded to Jean E. Mackie, Class of 1944. She purposes taking a course in clinical supervision. One Tegler scholarship goes to Olive Keith, assistant supervisor of the children's ward, who will take the course in clinical supervision with pediatrics the specialty chosen. The other Tegler scholarship has been awarded to Florence Watkins, charge nurse on the men's surgical ward. She will also take the course in clinical supervision, specializing in surgical nursing.

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### BRITISH COLUMBIA

KAMLOOPS:

The annual meeting of the Kamloops-Okanagan District, R.N.A.B.C., was held recently with about forty members for dinner, among whom were delegates representing the six chapters — Salmon Arm, Vernon, Penticton, Kelowna, Princeton and Kamloops-Tranquille. At the conclusion of dinner the members were delightfully entertained with musical numbers supplied by local talent. Following this the business meeting was conducted by the president, O. Garrood. The delegates read interesting reports of their year's activities, showing that much had been accomplished.

Helen MacKay, of the Royal Inland Hos-

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in just 14 days!

**Compare your complexion** with your shoulders. You'll find your shoulders look 5 or more years younger. Why? Because shoulder pores are kept clean by your regular Palmolive Soap baths —and so, *able to breathe freely*. But face pores, clogged with dirt and make-up, can't breathe freely and soon your complexion loses its *flexible softness* and ages before its time. That needn't happen to *your* complexion. Palmolive offers an easy way to keep it radiantly lovely.

**You can look younger in 14 days!** Wash your face 3 times a day with Palmolive, and each time, *with a face-cloth* massage Palmolive lather into your skin—for an extra 60 seconds! This easy Palmolive Massage stimulates the circulation, clears the pores to help your complexion regain its *flexible softness*, become *softer, smoother* in just 14 days!

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- Free from medicinal odor

Your recommendation on so intimate a matter as the vaginal douche will naturally seek to answer two important questions: Will it truly *cleanse?* Is it *safe* and non-injurious to the tissues? In advising the use of Lorate you assure your patients a douching preparation which is cleansing and deodorant yet non-astringent and soothing.

**LORATE**

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. . . releases nascent oxygen—an excellent detergent. Has a pleasing fragrance—free from medicinal odor. May be safely and effectively used as a routine douche; after menstruation; in leukorrhea; after childbirth; during the menopause and in trichomonas vaginalis and other forms of vaginitis.

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PROTECTS YOUR CLOTHING:
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No disagreeable body odours.
AND LASTS TWICE AS LONG!

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2. Apply Odo-Ro-No freely with patented non-drip applicator. Let dry thoroughly.

3. Rinse the underarms well with clear water or wipe off with a damp cloth.

4. If these directions are followed, you and your garments will be doubly protected.

DEVELOPED BY A MEDICAL MAN FOR THE PROFESSION

This preparation was developed by a medical man to stop perspiration on his hands while performing surgical operations.

The FASTIDIOUS prefer
ODO-RO-DO
Liquid

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Regular: 3 to 5 days' protection

Instant: Faster drying than "Regular"—1 to 3 days' protection.

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pital, was asked to take the chair for the election of officers for the coming year. Miss Garrood was unanimously returned to office for a second year of able presidency. Mrs. M. Pegeau of Penticton was elected vice-president and Mrs. W. R. Waugh, Kamloops, secretary-treasurer. The conveners of the various committees were elected as follows: Mrs. Mary Barton, hospital and school of nursing; Miss Newby, of Kelowna, public health; I. Harbell, of Salmon Arm, general duty and private nursing. Miss Garrood was voted councillor to the provincial executive, and Helen MacKay as delegate to attend the provincial annual meeting. The new vice-president then extended a hearty invitation to hold the district meeting next October at Penticton.

The speaker of the evening was Dr. F. A. Humphreys, bacteriologist of the Laboratory of Hygiene, Department of National Health and Welfare, who spoke on "Tick and Insect Borne Diseases". Slides were shown depicting closeups of tick and insect life which proved both interesting and instructive. Mrs. Barton thanked the speaker. Several of the student nurses from the Royal Inland Hospital arrived in time to enjoy Dr. Humphreys' lecture.

During the afternoon the visiting delegates and executive of the Chapter were entertained at the home of Mrs. Roy Bell.

The Valentine tea held in February was a great success, $272.25 being realized from the apron stall, white elephant table, tea and raffle.

## CHILLIWACK:

Miss D. Priestley, retiring president of the Chilliwack Chapter, R.N.A.B.C., dealt briefly with the four years work done by the organization here at the recent annual meeting. An interesting note was the fact that Miss Claire Tait, first president of the Chapter, has accepted a position with UNRRA and will serve in Europe. Miss Priestley extended thanks to matrons of Chilliwack Hospital, Chilliwack Military Hospital and Coqualeetza Indian Hospital for acting hostesses, and to officers and members for loyal support.

New officers include: A. McKay, president; M. s. E. B. M. Kennedy, vice-president; E. Morton, secretary; F. Roberts, treasurer; chairmen of sections: K. Crowley, hospital and school of nursing; D. Priestley, public health; Mrs. C. S. Pennock, general nursing. Standing committees include: program, Mmes. H. R. Hatfield, H. K. Arnould; refreshments, F. Roberts, J. Hall E. Sloane; membership, T. Fagan, M. F. Bridges, Mrs. Carl Webb; *The Canadian Nurse*, L. Hodgkins; press and publications, Mrs. J. D. Munroe; visiting, Mrs. Storey; ways and means, Mrs. T. E. Heaton.

A committee was appointed to handle Special Nurses Emergency funds. Two gift subscriptions to *The Canadian Nurse* will be sent to Chilliwack girls graduating this year.

*Whenever mild laxation is needed...*

**Phillips' Milk of Magnesia is generally accepted by the medical profession as a standard therapeutic agent, being so recognized for more than 60 years.**

***As a laxative***—it is gentle, smooth-acting without embarrassing urgency.

***As an antacid***—Prompt, effective relief. It contains no carbonates, hence no discomforting bloating.

*Dosage . . .* (*laxative*) 2 to 4 tablespoonfuls (*antacid*) 1 to 4 teaspoonfuls *or* 1 to 4 tablets

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## NOVA SCOTIA

NEW GLASGOW:

The unveiling of a plaque honouring graduates from Aberdeen Hospital School of Nurses who had entered the fighting services took place recently in the presence of more than fifty persons.

The plaque was donated by the Aberdeen Hospital Alumnae Association and was unveiled by Mrs. Eaton, the oldest graduate. Mrs. Harry Murray, president of the Alumnae Association, spoke briefly, and Canon I. E. Fraser noted the service of Florence Nightingale in war and how her example had been followed. Dr. W. H. Robbins told of the services he had seen nurses perform in the last war.

The plaque has been placed on the wall of the waiting room by the main entrance of the hospital. Tea was served by Alumnae members at the conclusion of the ceremonies.

Following are the names of the graduates of Aberdeen Hospital who are now in the services: Frances Charman, Nellie Mills, Ethel Duncan, Ruth Milligan, Helen Morash, Isabel Thompson, Mae MacChesney, Evelyn Negus, Mabel MacKenzie, Ruth Fawcett, Sarah Miller, Jean Johnson, Beryl Ripley and Margaret Treen.

The Alumnae Association recently held a rummage sale which netted $90. The proceeds will go towards the endowment of a room in the new hospital which is under consideration.

## ONTARIO

*Editor's Note*: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto

### DISTRICTS 2 AND 3

*Brantford General Hospital*:

The graduation exercises of the Brantford General Hospital School of Nursing took place recently when The Most Rev. C. A. Seager, D.D., Archbishop of Huron, addressed the class. In the afternoon a garden party was held at the hospital. In the evening a dance was much enjoyed by the nurses

## BACK COPIES WANTED

To complete the set of bound volumes in the office of **The Canadian Nurse** the following issues of the **Journal** are required:

1911: **Jan.** to **Dec.** inclusive.

1912: **Jan.** to **Dec.** inclusive.

1913: **Jan.** and **Oct.**

1914: **Jan., Feb.** and **June.**

If any subscriber has these issues in their possession and would be willing to sell them, kindly communicate with the **The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.**

## Proper Illumination

Requests for illumination studies are being made with increasing frequency. Certain factors are found common to all of the places studied and are probably typical of situations in office cubicles. These are:

1. An intensity of illumination from artificial sources entirely inadequate to meet the needs of the seeing job being done.

2. A serious degree of glare at windows resulting either from direct sunlight or sunlight reflected from light coloured buildings.

3. Excessive contrasts in degree of illumination as a result of desk lights used in an effort to correct for inadequate intensities of general illumination.

Replacement of incandescent lighting fixtures with fluorescent lighting fixtures provides the most desirable remedy in most cases. Modern fixtures are difficult to obtain, however, and the changes in wiring increase the cost.

—*California's Health*

and their friends. A week later the Alumnae Association entertained the graduates at a banquet and dance.

The Association held their closing meeting for the season on the terrace of the hospital grounds, where an enjoyable picnic lunch was served. Miss Helen Cuff, the president, conducted the meeting and the election of officers took place as follows: Honourary president, J. M. Wilson; president, H. Cuff; vice-president, O. Plumstead; secretary, M. Patterson; treasurer, Mrs. J. Oliver; committees: gift, J. Landrette, V. Buckwell; flower, M. Malloy, L. Burtch; social, Mmes J. Grierson, P. Smith; representatives to: Local Council of Women, Mrs. E. Walton; Red Cross, Mrs. A. D. Riddell; *The Canadian Nurse* and press, D. Franklin.

### District 4

HAMILTON:

A regular meeting of the Hamilton Chapter, District 4, R.N.A.O., was held recently at St. Joseph's Hospital, with Miss Blackwood presiding. Miss Jean Masten, president of the R.N.A.O. and superintendent of nurses, Hospital for Sick Children, Toronto, presented to the meeting some of the more recent trends in nursing such as "The Practice Act", which would give legal status to nurses, the advisability of setting up a placement bureau for the Province, and the possibility of a pension fund for nurses. Miss Masten also spoke of the great need existing among the European nurses for uniforms, shoes, etc. To help meet this need all Canadian nurses will be given an opportunity to make a contribution.

WELLAND:

The last regular meeting of the Welland Graduate Nurses Association took the form of a business meeting with Mrs. C. Hill in charge. The room committee reported the purchase of a new mattress and was asked to have the room linen brought up to the standard amount. The final financial reports were read and a satisfactory bank balance was revealed. Fall activities were also discussed and a social hour followed.

At the annual dinner some sixty nurses were present from the various branches of nursing in the city. Mrs. Peggy Sharp and Mrs. Marg Beatty won door prizes donated by Miss Rossi. Many enjoyed a walk on the terrace after dinner and card games were played.

### District 7

BROCKVILLE:

Miss Kay Kerr, secretary of the Brockville Chapter, District 7, R.N.A.O., reports

that a recent meeting was held in the Ontario Hospital, with Miss Preston, the newly-elected president, in the chair. Mrs. Gilpin introduced the guest speaker, Dr. Barrie, who spoke on "Electro Shock Therapy". To stimulate interest it was decided to have an advertisement inserted in the local paper twice during the week preceding the meeting night and to include the name of the speaker. Mrs. Orr and her staff later served refreshments.

KINGSTON:

The Hotel Dieu Hospital will celebrate its one hundredth anniversary on September 11 of this year. It is the sincere wish of the Rev. Mother Superior that all graduates of the Training School will make a special effort to be present and to celebrate with the Sisters this memorable event. Invitations will be sent to each graduate in the near future and the Alumnae would appreciate names and addresses for its mailing list.

Among the Hotel Dieu graduates at the new Veterans Hospital on Princess St. are Rita Davis, Marjorie O'Toole, Esterine Johnston, Rita Cassidy, Margaret Stephens, Mildred Kennedy, Marjorie McGrath, Margaret Coderre, Eulia Wilkinson, Marcella O'Meara, Willena Hurley.

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## QUEBEC

MONTREAL:

*Children's Memorial Hospital*:

At a recent meeting of the Staff Association, as part of the education program, Dr. M. Digby Leigh, chief anesthetist, gave an interesting and informative talk on "Oxygen Therapy", complete with a film presentation and practical demonstration. The teaching department, together with the staff nurses, have been busy revising the student nurses' report forms. The present issue under discussion is the question of improving charting methods.

The following nurses have successfully completed their six-month post-graduate course: Norah Edgar (St. Boniface Hospital, Man.); Christena Geddes (Misericordia Hospital, Edmotnon); Ruby Dewar (Dauphin General Hospital, Man.)

The new class of post-graduates started May 15. They are Brenda Corker (Royal Columbian Hospital, New Westminsteri; Yacko Nagai (Vancouver General Hospital); Marie Linkletter (St. Joseph's Hospital, P.E.I.); Pauline Wright (Royal Jubilee Hospital, Victoria).

Recent appointments to the staff are Christena Geddes, Doris Lloyd and Pauline Markham (Hotel-Dieu, Windsor). Joan McPhail has resigned.

Keep them healthy—let Baby's Own Tablets help you. Pleasant, simple tablet triturates, they can be safely depended upon for relief of constipation, upset stomach, teething fevers and other minor ailments of babyhood. Warranted free of narcotics and opiates. A standby of nurses and mothers for over 40 years.

**BABY'S OWN Tablets**

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**SOCIAL ASPECTS OF TUBERCULOSIS**

**By S. Roodhouse Gloyne.** Public health and other nurses will find this new British book of special interest. It is an enlargement of lectures given at the Royal College of Nursing to health visitor students. It deals with infection, resistance and other problems as they concern both the individual and the community. $2.50.

**THE NURSE AND THE LAW**

**By Gene Harrison.** "The nurse's chief concern is not only to avoid tangles with the law, but also to know enough about law to enable her to give hope and comfort to her patient if occasion arises." — **L. E. Dickinson, M.D.**

"There should be a place on the shelves of each nurse, beside her medical books, for this volume, in which an attempt has been made to fill a want hitherto unsatisfied." — **J. H. Harrison, Attorney-at-Law.** $3.75.

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**Assistant Instructor of Nurses; Instructor of Nurses** to act also as **Assistant Superintendent** of small hospital; **Night Supervisors; Supervisors** and **Head nurses** for **Operating Room, Private Patients, Maternity Divisions; General Staff (General Duty) nurses** for general and special hospitals; **School Nurses; Infant Welfare nurse; Nurse** in **Industrial** plant; **Record Librarian.**

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*Royal Victoria Hospital:*

Bertha Cameron and Elizabeth Stewart spent a week recently observing in neurosurgery and urology at New York Hospitals. Henrietta Adams and Jean Trenholm recently visited the Massachusetts General and the Peter Brent Brigham Hospitals. Marian McEwen, of the outdoor department staff, recently joined the R.C.N. Nursing Service.

N/S's Rita Ackhurst, Rita Fulton, Margaret Mowatt and Doris Carter were recent visitors at the hospital from overseas.

*St. Mary's Hospital:*

The annual dinner tendered by the Alumnae Association of St. Mary's Hospital School for Nurses for the graduating class was held recently with Mrs. W. E. Johnson, president of the Association, presiding. At the head table were Alyce McKenna, Regina Cowan, Patricia Corbett, president of the graduating class, Rev. Father A. Carter, Chaplain of the Association, Ena O'Hare, N/S Mary Morrow and Emily Toner.

Father Carter addressed the nurses and commended their spirit of unity and comradeship. Toasts were proposed by E. Toner, M. Barrett, G. Kennedy, E. O'Hare, and P. Corbett thanked the Association in the name of the new graduates. Arrangements for the dinner were in charge of T. DeWitt, Mrs. T. Cherry, D. Sullivan and C. Lewis.

A recent visitor to town was N/S Claire Robillard on furlough from the U.S. Army Nurse Corps. Claire has been doing some interesting work in anesthesia and has seen action in China, India and Burma. Catherine Dupuis writes from Santa Barbara, Calif., that she has made application to nurse with the U. S. Navy Nurse Corps. Anne-Marie Kingston has been awarded a two-year scholarship at the University of St. Louis. Miss Kingston will take a post-graduate course in public health nursing. The degree of Bachelor of Science in Nursing has been conferred on Claire MacDonald from the University of St. Francis Xavier.

QUEBEC CITY:

*Jeffery Hale's Hospital:*

The graduation exercises of the Jeffery Hale's Hospital School of Nursing were held recently with a large number of relatives and friends present. Mr. J. T. Ross, assisted by Miss M. E. Lunam, presented the graduates with their diplomas and medals. Following the exercises a reception was held. A formal dance was given by the staff and Board of Governors, in honour of the Class of 1945, and the Alumnae Association also entertained the Class at dinner.

The graduating class recently held a Wartime Tea for friends in the city.

M. Taylor and M. Dickson have left to take up their duties with the Royal Canadian Navy. Mrs. Mashell has resigned as supervisor of the semi-private and pediatric wards and has been replaced by Miss Coull. Mrs. Pfeiffer has replaced Mrs. Mashell as treasurer of the Alumnae Association.

All nurses of J. H. H. who wrote the Spring examinations for registration passed successfully.

## SASKATCHEWAN

### Maple Creek Chapter:

A dance under the auspices of the Maple Creek Chapter was held recently. Part of the proceeds have been forwarded to the British Nurses Relief Fund. The Chapter is subscribing to the *Digest of Treatment* and at each meeting some of the articles will be read and discussed.

### Moose Jaw Chapter:

The first Thursday in each month five local nurses, each keenly interested in the public health field, meet for an informal luncheon. Those attending are Mmes B. Farquharson, A. Tanney, Misses K. Jamieson, N. Armstrong, La Roque.

Grace Motta, superintendent of nurses, Moose Jaw General Hospital, represented the S.R.N.A. at the recent convention of the Provincial Council of Women held in Moose Jaw.

Kristie Jamieson recently spoke to the Central Collegiate Home Nursing class on Venereal Disease. Her lecture was met with much enthusiasm and interest by the forty-two members present.

### Prince Albert Chapter:

The following nurses on the Victoria Hospital staff, Prince Albert, are taking post-graduate courses at the Vancouver General Hospital: Mrs. Jean S. Harry, Marjorie Wilson, Gladys Anderson. Noreen Lambert, a 1945 graduate of the University of Saskatchewan School of Nursing and

**EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA**

To take place on October 17, 18 and 19, 1945, at **Halifax, Yarmouth, Amherst, Sydney, and New Glasgow.** Requests for application forms should be made at once, and forms MUST BE returned to the Registrar by **September 17, 1945,** together with: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Diploma of School of Nursing; (4) Fee of $10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations, and is within six weeks of completion of the course of Nursing.

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Applications are invited for the position of **Classroom Instructress.** Salary, $120 per month, plus full maintenance, including uniforms and laundry. Four weeks vacation following one year's service. Apply, stating qualifications and experience, to:

**The Secretary, Board of Commissioners, Nova Scotia Hospital, Dartmouth, N.S.**

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A **Matron** is required **immediately** for the **Swift Current General Hospital** of 75 beds. No training school. Applicants should state full particulars as to experience, references, salary desired, and when available. Apply to:

**E. H. Rice, Secretary-Manager, Box 10, Swift Current, Sask.**

WANTED

An **Assistant Superintendent** is required for the **Kootenay Lake General Hospital, Nelson, B. C.** Apply, stating experience, to:

**Kootenay Lake General Hospital, Nelson, B. C.**

St. Paul's Hospital, Saskatoon, has accepted a position on the staff of the Holy Family Hospital, Prince Albert, as instructor. Miss Lambert graduated with distinction from the University and was presented with the award for theory at St. Paul's.

### Regina Chapter:

Annual Vesper Services were held in the Metropolitan Church and in the Chapel of the Grey Nuns' Hospital in May with many nurses in attendance. Mrs. E. Martin has taken up her new duties as a public health nurse. She was formerly supervisor of the children's ward, Grey Nuns' Hospital. Mrs. Dorothy Weaver has resigned her position with the Cancer Clinic, Regina, after two and a half years service.

### Saskatoon Chapter:

Well-attended Vesper Services for nurses in Saskatoon were held in May at St. John's Cathedral and St. Mary's Church.

### Yorkton Chapter:

In observance of Hospital Day a successful tea was recently held by the Yorkton Chapter at the Yorkton General Hospital. During the day more than one hundred guests were received.

Alice Gwilliam, of the Yorkton General Hospital operating room staff, has completed a post-graduate course in surgery at Vancouver General Hospital and has returned to the position of supervisor of the operating room.

## WANTED

A qualified **Instructress** is required **immediately** for the **Carman General Hospital**. Apply stating qualifications, experience, and salary expected, to:

**Superintendent, Carman General Hospital, Carman, Manitoba.**

## WANTED

Registered Nurses are required **immediately** for **General Duty** in **Ex-Servicemen's Pavilion.** Nurses are also required for **Operating Room** and **Obstetrical Unit.** Salaries depending upon experience. Full maintenance living out. Railway fare to Edmonton refunded after six months' service. Apply, stating experience, to:

**Superintendent of Nurses, University Hospital, Edmonton, Alta.**

## WANTED

Nurses are required for **General Duty** in the **Verdun Protestant Hospital, Montreal.** This is a splendid opportunity to obtain psychiatric nursing experience. State in first letter experience, references, etc. and when services would be available. Apply to:

**Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.**

## WANTED

A **Lady Superintendent** and **two nurses** are required for the **Barrie Memorial Hospital** in **Ormstown.** For full particulars write to:

**The Medical Superintendent, Barrie Memorial Hospital, Ormstown, P.Q.**

## WANTED

A **Nursing Superintendent** and an **Assistant Night Supervisor** are required **at once** for the **Cornwall General Hospital.** Apply, stating experience and salary expected, to:

**F. Stidwill, Secretary-Treasurer, Cornwall General Hospital, Cornwall, Ont.**

## WANTED

An experienced **Operating Room Nurse** as **Office Nurse** is required for a doctor in a middlesized **Saskatchewan** town. Duties are to begin on **September 1.** Beginning salary, $150 per month. Apply to:

**Dr. W. Bergmann, Meadow Lake, Sask.**

## WANTED

Applications are invited for the position of **Superintendent** of a 55-bed General Hospital with an 18-bed Maternity Annex. Apply, stating qualifications, experience, and salary expected, to:

**Secretary, Board of Trustees, Colchester County Hospital Trust, Truro, N. S.**

## WANTED

**A Registered Nurse** is required for **Night Duty.** Salary, $90 per month, plus full maintenance. One full night off each week. Apply to:

**Scott Memorial Hospital, Seaforth, Ont.**

## WANTED

**General Duty Nurses,** registered or graduates, are required for the **Lady Minto Hospital.** The salary is $90 and $80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

**Lady Minto Hospital, Cochrane, Ont.**

## WANTED

Applications are invited for the following positions in a 100-bed hospital with Training School:

**Dietitian** — required at once.

**Instructor** — required for **September 1, 1945.**

For further information apply to:

**Sister Superior, Providence Hospital, Moose Jaw, Sask.**

## WANTED

An **Operating Room Nurse** is required immediately for a 200-bed **Children's Hospital.** Salary, $85 per month, and maintenance. 96-hour fortnight. Apply to:

**Superintendent of Nurses, Children's Memorial Hospital, Montreal 25, P. Q.**

## WANTED

**A Superintendent of Nurses, Dietitian,** and **Instructress** are required **immediately** for the **Highland View Hospital.** Apply, stating qualifications, to:

**Secretary, Highland View Hospital, Amherst, N. S.**

## WANTED

An **Assistant Superintendent** and a **Clinical Supervisor** are required for a 180-bed hospital in **Southern Ontario.** Student body, approximately 40. Apply, stating qualifications and salary expected, to:

**Superintendent of Nurses, Niagara Falls General Hospital, Niagara Falls, Ont.**

## WANTED

**General Staff Nurses** are required for the **Women's Missionary Hospital of the United Church of Canada at Hearst, Ont.** The salary is $100 per month, with full maintenance, less tax. Apply to:

**Superintendent, St. Paul's Hospital, Hearst, Ont.**

## WANTED

A qualified **Dietitian** is required for a 117-bed General Hospital. Apply to:

**Superintendent, St. Joseph's Hospital, Peterborough, Ont.**

## WANTED

A **Senior Instructor of Nurses** is required for a Training School of 60 pupils. Salary, $135 per month. Apply, stating qualifications, age, religion, etc., to:

**Superintendent, Glace Bay General Hospital, Glace Bay, N.S.**

## WANTED

**A Registered Nurse** is required as **Night Supervisor**; three Registered nurses are also required for **General Staff Duty.** Eight-hour day and six-day week, with full maintenance. Apply, stating salary expected, to:

**Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit, Montreal 25, P. Q.**

## WANTED

**General Staff Nurses** are required for **Psychiatric Teaching Centre.** Straight eight-hour day, with one full day off duty weekly. Three weeks holiday a year; accumulative sick leave. Minimum annual salary, $1200 less perquisites. Apply to:

**Director of Nurses, Toronto Psychiatric Hospital, Toronto 5, Ont.**

## WANTED

**An Assistant** to the **Superintendent of Nurses** is required by the **Sherbrooke Hospital.** Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available **immediately.** Apply, stating qualifications, experience, and salary expected, to:

**Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.**

## WANTED

**General Duty Nurses** are urgently required for a 350-bed **Tuberculosis Hospital.** Forty-eight and a half hour week, with one full day off. The salary is $100. per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

**Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.**

## WANTED

**A Superintendent** is required for the **Galt General Hospital** of 90 beds. Applicants should have had post-graduate training in Administration and Teaching, and experience in the administration of a Training School. Apply, stating references, experience, and salary expected, to:

**H. N. Simmons, Secretary, Galt Hospital Trust, City Hall, Galt Ont.**